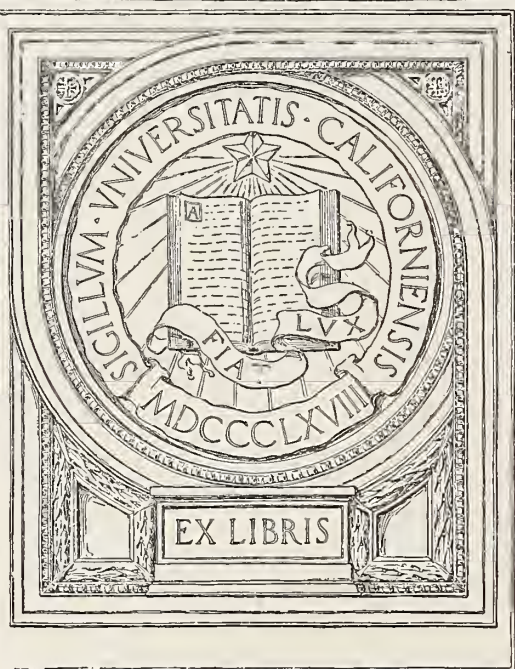




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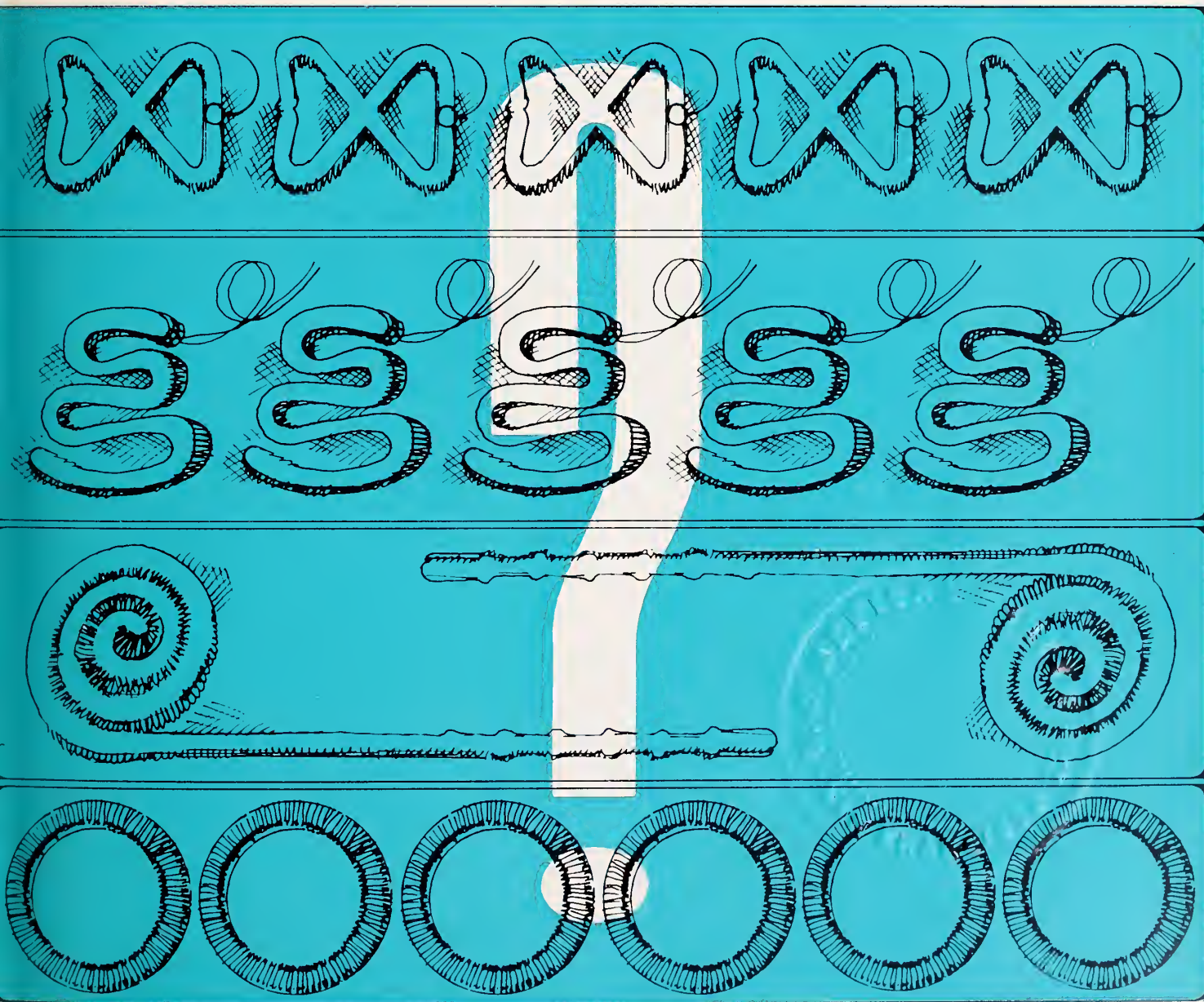
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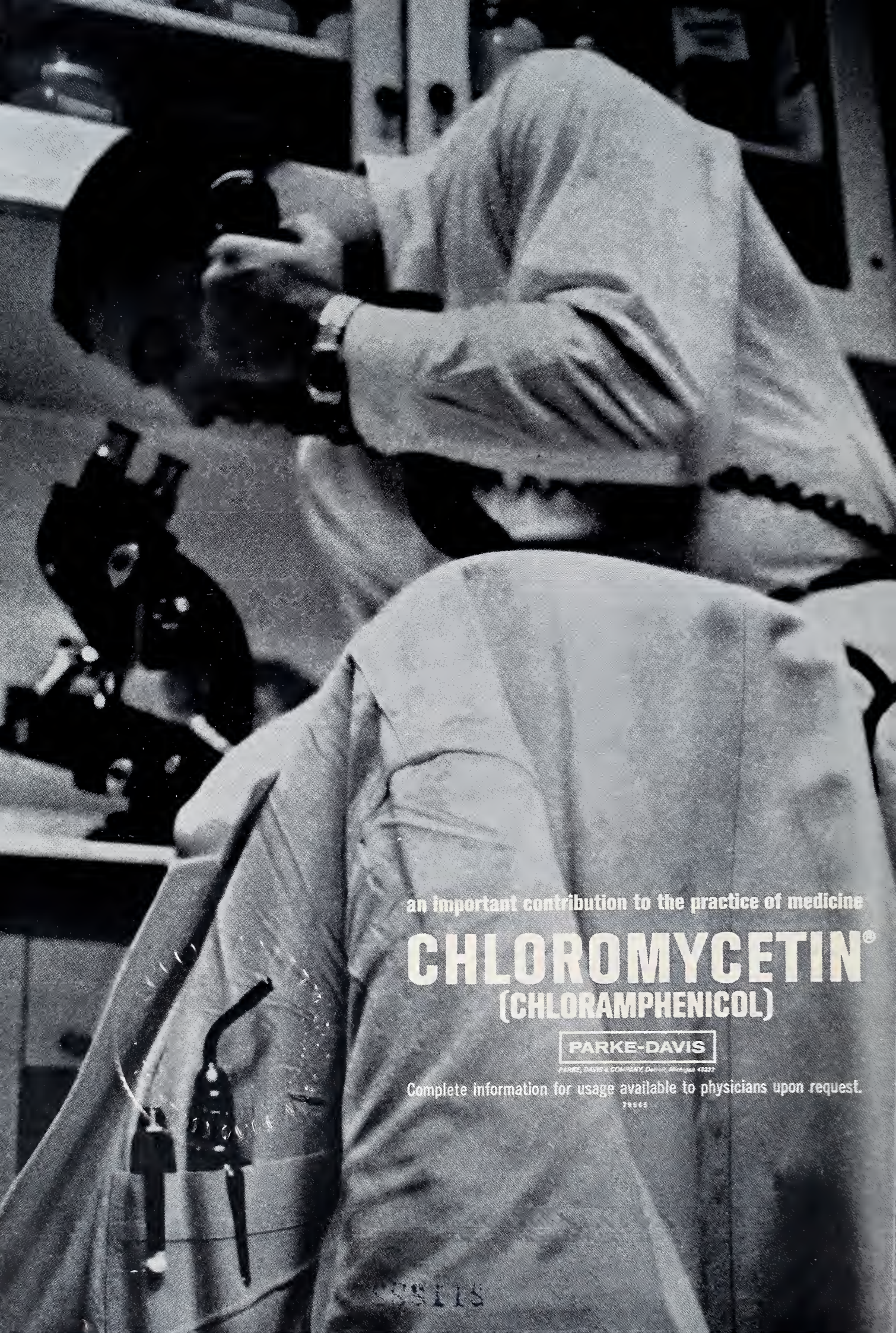
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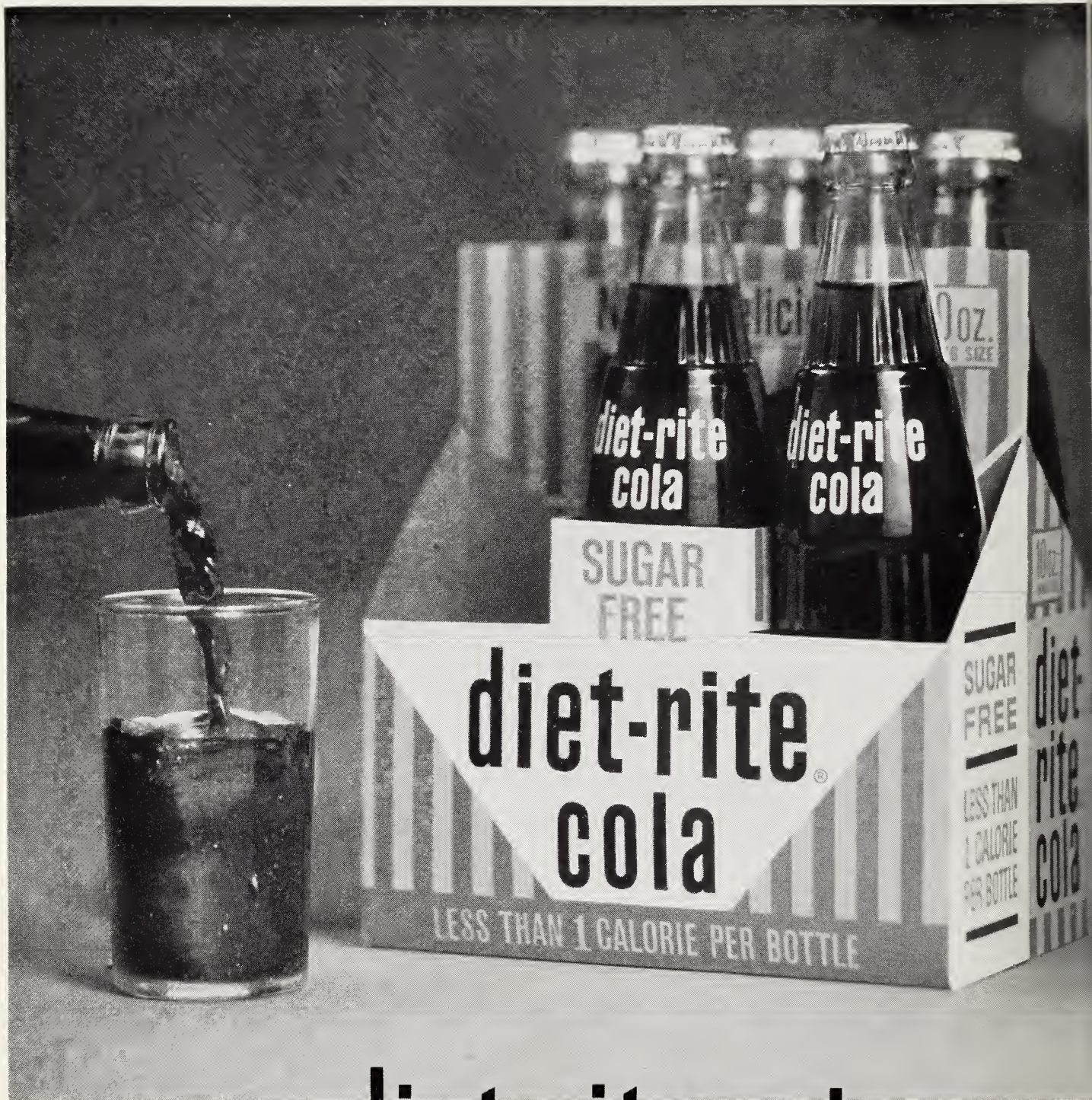
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# LACTIC ACIDOSIS IN CLINICAL MEDICINE

William C. Waters, III, M.D., *Atlanta*

- In this often fatal metabolic disorder, sodium bicarbonate is the first line of defense.

ALMOST every physician can recall from his experience a few instances of profound unexplained metabolic acidosis. Properly, in such circumstances, he has sought for the usual causes of such a condition, including diabetic keto-acidosis, uremia, or some ingestant such as salicylates, only to find that the patient's metabolic status remained a mystery. With Huckabee's description of the clinical syndrome of lactic acidosis in 1961,<sup>1</sup> it has become evident that many such cases correspond to this bizarre and, as yet, unexplained clinical entity.

## One Hundred Documented Cases

Since that time, nearly 100 cases of this phenomenon have been documented in the clinical literature. In general, the patients have been suffering from some serious illness, although many were not critically ill at the onset of the acidosis. Most such patients manifest a relatively abrupt onset of deteriorating consciousness, hyperpnea—generally of the Kussmaul type—and tachycardia; all but a few have eventually expired. The chemical counterparts of the syndrome include low blood pH, reduced bicarbonate concentration ( $\text{CO}_2$  content) of peripheral blood, and significant elevation of the blood lactate concentration.

## Two Distinct Categories

In general, two distinct clinical categories have evolved: the "secondary" form of lactic acidosis<sup>2, 3</sup> and the "spontaneous"<sup>3</sup> or "idiopathic"<sup>4</sup> variety. The secondary category consists of lactic acidosis developing in those settings in which tissue hypoxia is expected. Since lactate production is the biochemical hallmark of anaerobic metabolism,<sup>2</sup> it is not surprising that severe hypoxia, severe anemia, shock, profound cardiac failure, muscular exercise, or hypoxic pulmonary disease might well be associated with elevations above normal of the lactate concentration of blood plasma.

Interestingly enough, however, in most of these situations lactic acidemia is seldom of such magnitude as to produce clinically significant or threatening metabolic acidosis.<sup>2</sup> On the other hand, spontaneous lactic acidosis is, by definition, characterized by the appearance of profound and even lethal levels of hydrogen ion excess. It is typical of this spontaneous or idiopathic form that arterial  $\text{PO}_2$  and oxygen saturation are normal, peripheral blood pressure is maintained, cardiac failure is generally absent, the patient is not significantly anemic, and no traceable etiology for generalized tissue hypoxia is evident.<sup>2, 3</sup> No common denominator appears to underlie this group of disorders; indeed, Tranquada has recently tabulated the primary diagnoses in 71 patients with lactic acidosis of this variety, and lists 29 separate underlying disease processes.<sup>4</sup> Perhaps it is significant that uremia, diabetes mellitus, and bacterial infection have contributed heavily to the total; on the other hand, it is known that lactic acidosis generally is not a part of the acidosis of uremia, that only occasional diabetics manifest hyperlactatemia, and that the great majority of even overwhelming bacterial infections are not associated with excessive lactic acid accumulation.<sup>2-7</sup>

From a pragmatic clinical viewpoint, however, it is probably well to group the processes associated with lactic acidosis together as a check list, etiologically speaking: severe hypoxia,<sup>1, 2</sup> profound muscular exercise,<sup>8</sup> glycogen storage disease of the liver,<sup>9</sup> shock (both hemorrhagic and endotoxin),<sup>10, 11</sup> low-flow extracorporeal circulation,<sup>12, 13</sup> hyperthermia,<sup>14</sup> hyperventilation,<sup>15</sup> epinephrine injection,<sup>16</sup> methyl alcohol intoxication,<sup>17</sup> salicylate intoxication,<sup>18</sup> diarrheal dehydration in infants,<sup>19</sup> cardiac arrest, diabetes,<sup>6</sup> especially those receiving phenformin,<sup>5</sup> premature infants receiving lactic acid milk,<sup>20</sup> rare instances of familial chronic lactic acidosis,<sup>21</sup> and at least one instance of an obese diabetic on a total fast.<sup>22</sup>

With such a variegated array of disease processes, it is not difficult to imagine how the pathogenesis of clinically appearing spontaneous lactic acidosis continues to elude us. In the experimental situation, lactic acidosis can be consistently produced by a very limited number of maneuvers. Gradually produced hemorrhagic shock in dogs leads to progressive development of lactic acidosis which precedes the clinical development of hypotension, suggesting that ischemic tissue hypoxia may be the underlying mechanism.<sup>1</sup> On the other hand, certain toxic agents, notably guanidine, when injected into experimental animals will regularly produce profound lactic acidosis,<sup>23</sup> possibly by means of a histotoxic mechanism, though this explanation is by no means certain. The frequent clinical occurrence of lactic acidosis in situations of impaired tissue blood flow, as in prolonged hypovolemic shock or in inadequate flow in the course of cardiopulmonary bypass procedures, adds further to the "stagnant anoxia" hypothesis. Since lactic acidosis has been observed in the endotoxin shock of gram-negative bacteremia, it is possible that impairment of the efficiency of the microcirculation (as suggested by Lillehei for gram-negative shock)<sup>24</sup> may be fundamental to the clinical syndrome. It has been suggested that occult impairment of the cytochrome oxidase system may shift the "load" of energy production to the auxiliary anaerobic pathway,<sup>25</sup> with the consequent production of lactic acid in excess, but this possibility, too, remains speculative.

Recognition Improving

While the pathogenesis of spontaneous lactic acidosis remains shrouded in mystery, the ability of the clinician to recognize the syndrome in its full-blown form is steadily improving.<sup>3</sup> As previously pointed out, the patient with lactic acidosis an-

nounces his status with a general deterioration of his clinical status and by prominent hyperpnea. Such manifestations bring up the differential diagnosis of primary respiratory alkalosis versus primary metabolic acidosis. The former frequently appears with pulmonary emboli, cerebral vascular accidents, gram-negative bacteremia, or hepatic encephalopathy. Both acid-base disturbances are, of course, characterized by a fall in the plasma bicarbonate and PCO<sub>2</sub>, but the distinction between the two metabolic abnormalities is readily made by means of blood pH determination. Once it is established that metabolic acidosis is present, it remains for the clinician to dissect away the various possibilities (Table I). Since plasma lactate determinations are not readily available, the diagnosis is generally made by exclusion. If the "anion gap" is elevated, then it becomes necessary to rule out diabetic keto-acidosis, salicylate intoxication, methyl alcohol poisoning, paraldehyde or ethylene glycol poisoning, and azotemic renal failure. Once these entities are excluded, lactic acidosis becomes extremely likely. In addition to this negative approach, several characteristics of lactic acidosis may aid in its clinical recognition. These characteristics include abrupt appearance of tachypnea followed by stupor; apparent "resistance" to alkali therapy, in which large amounts of sodium bicarbonate may fail to effect a change in plasma bicarbonate concentration; and finally, a tendency for the acid-base status of the patient to swing spontaneously from acidotic to alkalotic levels and perhaps back again.<sup>3</sup> It is important to note that compound metabolic acidosis can occur.<sup>3</sup> That is, lactic acidosis may become superimposed upon azotemic renal insufficiency wherein acidosis already exists, or diabetic keto-acidosis and diabetic lactic acidosis may be combined. Such distinctions can generally be made even here, however, by recognizing the fact that uremic acidosis is essentially never abrupt in appearance, and by noting that acidosis—persisting in a given diabetic beyond the point where ketone bodies

TABLE I  
CLASSIFICATION OF METABOLIC ACIDOSIS

Etiology	Mechanism of Acidosis
With increase in unmeasured anions	
Diabetic keto-acidosis	Accumulation of acetoacetic and beta-hydroxybutyric acids
Salicylate intoxication	Uncertain, probably accumulation of lactic acid
Methyl alcohol poisoning	Accumulation of ketone acids, formic acid, and probably others
Paraldehyde intoxication	Unknown
Ethylene glycol poisoning	Unknown
Azotemic renal failure	Diminished H <sup>+</sup> secretion by renal tubular cells (phosphate, sulfate and organic anions usually retained simultaneously)
Lactic acidosis	Accumulation of lactic acid
Without increase in unmeasured anions (hyperchloremic acidosis)	
Diarrhea	Loss of bicarbonate in stool
Ammonium chloride	Metabolism of NH <sub>4</sub> <sup>+</sup> by liver with addition of H <sup>+</sup> to ECF
Renal tubular acidosis	Diminished H <sup>+</sup> secretion by renal tubular cells
Chronic pyelonephritis (occasionally)	Diminished H <sup>+</sup> secretion by renal tubular cells
Ureterosigmoidostomy	Loss of HCO <sub>3</sub> <sup>-</sup> by exchange across colonic mucosa



have disappeared from his serum—suggests a second process is in operation.

It is interesting, even tantalizing, to compare the syndrome of lactic acidosis as we know it today with diabetic keto-acidosis as it was faced by clinicians prior to the advent of insulin. In his textbook of medicine, for instance, Osler recommended that patients in diabetic acidosis be given approximately 1,200 milliequivalents of sodium bicarbonate daily.<sup>26</sup> and in some instances reports indicated that amounts of 2,000 to 4,000 milliequivalents were necessary in order to raise the plasma concentration to normal or near-normal levels.<sup>27</sup> With the availability of insulin, of course, it is possible to restore to the ketotic diabetic the capacity to metabolize ketone acids, with the consequent regeneration of bicarbonate. It is unfortunate that our present state of knowledge does not allow us to restore to the patient with lactic acidosis the biochemical faculty to metabolize lactate. If this were possible, the patient with metabolic acidosis due to accumulation of lactic acid might well behave like the runner who has just completed a 400-meter sprint. Such an athlete may accumulate more than 20 milliequivalents of lactate per liter of serum, only to metabolize it promptly, with restoration of normal acid-base economy.<sup>28</sup> This biochemical pathway in the patient ill with lactic acidosis, however, is apparently obstructed.

## To Be Avoided

For this reason, in the consideration of therapy of lactic acidosis, it should be pointed out that alkalinizing solutions containing sodium lactate are to be avoided.<sup>29</sup> Since the pathway for disposal of the lactate ion is in some strange way blocked, it is apparent that the readily available, relatively inexpensive, safe, and highly predictable substance sodium bicarbonate should be administered in amounts which are adequate to restore blood pH near the physiologic range of 7.35 to 7.45. In addition, it is mandatory in all cases of lactic acidosis to search for underlying etiologies: Is the patient anoxic? Is clinically inapparent shock present? Is the patient hypovolemic? Is congestive heart failure part of the picture? Is bacteremia present?

## Status Closely Followed

Once these questions are resolved and appropriate therapy instituted, the patient's acid-base status must be followed at frequent intervals, much like the patient with diabetic keto-acidosis, to insure that neither lethal acidosis nor unexpected swings to metabolic alkalosis interfere with the patient's internal environment.<sup>3</sup> A variety of other therapeutic maneuvers have been employed, including peritoneal lavage<sup>4</sup> and hemodialysis,<sup>30</sup> with no definite benefit.

Such agents as methylene blue, a redox agent, has been used in the therapy of lactic acidosis with demonstrable effect on lactate levels, but with an unpredictable influence on the underlying acid-base status and with no clear influence on final outcome.<sup>31</sup> The buffer agent TRIS (2-amino-2 hydroxy methyl 1, 3-propanediol) has been used effectively in correction of the lactic acidosis associated with extracorporeal circulation,<sup>13</sup> but this agent must, of course, be used with great caution because of the respiratory depressant effect in any individual whose ventilation is not being maintained artificially.

## Dramatic Metabolic Disease

Lactic acidosis, then, is a relatively newly-recognized, dramatic metabolic disease characterized by the rather rapid development of clinically significant metabolic acidosis. An increased concentration of unmeasured anions (anion gap) is present; the acid-base status may be relatively refractory to alkali therapy; unexpected swings in acid-base economy occur; and the prognosis is poor. Adequate therapy consists of the search for hypoxia and clinically inapparent shock, and of protection of the patient from lethal acidosis by means of sodium bicarbonate therapy. In view of our grossly inadequate understanding of the fundamental biochemical lesion, the patient with lactic acidosis today resembles the patient with diabetic keto-acidosis in 1920; continuing the analogy, one would hope that a specific agent—like insulin—will soon become available.

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Emory University School of Medicine

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Emory University School of Medicine offers an impressive postgraduate program. For example, during the academic year 1965-66, the school has offered, or will offer, at least nine postgraduate courses lasting from two to five days. Additional courses for the current academic year are being planned.

Commenting on the importance of the school's postgraduate program, Dr. Arthur P. Richardson, Dean of Emory University School of Medicine, said: "The gap between what is known and what is applied is increasing rapidly. We take the view that our educational responsibilities do not end with the giving of the M.D. degree or on completion of a residency. On the contrary, we try to make educational opportunities available to practicing physicians everywhere. Such programs help lessen the gap between what is known and applied.

### School Benefits

"We also feel that we in the medical school benefit from these courses. They bring members of the faculty in contact with physicians practicing in many different areas and we, in turn, learn from them."

The school also attempts to meet specific needs of individual physicians. Recently one practicing physician commuted from a small Georgia town in order to spend one day a week at Grady Memorial Hospital, where medical students receive their clinical training in their junior and senior years. He participated in ward rounds

and conferences and read in the Grady Branch of the medical school library. He did this for about two years.

Dr. J. Willis Hurst, professor and chairman of the department of medicine, Emory University School of Medicine, is chairman of the school's postgraduate program committee which consists of Drs. Richard Blumberg, J. D. Martin, J. Dan Thompson and H. S. Weens.

The students for the formal postgraduate courses come from over the nation and from many foreign lands. At least 1,000 persons attend one or more each year. Members of the Emory medical school faculty, along with national and international authorities in specific areas of medicine, teach the courses. They endeavor to bring the very best in medicine to physicians enrolled. Most of the courses are conducted in the auditorium of Grady Memorial Hospital.

### Courses Scheduled

Dates of scheduled courses for the current academic year, the subject of the course, and the sponsor are: August 25-27, and September 27-October 1, Internal Medicine, Department of Medicine; November 5-6, Radiology of the Bones and Joints, Department of Radiology; November 11-13, Newer Developments in Surgery, Department of Surgery; November 15-19, Conferences on Gynecologic Cancer, Department of Gynecology and Obstetrics; March 7-9, Renal Problems in Children, Department of Pediatrics; March 16-18, Clinical Aspects of Renal-Endocrine Interactions, Department of Medicine; March 28-29, Conference on Family Planning, Department of Gynecology and Obstetrics; April 4-5, Pharmacology for the Anesthesiologist; Opiates and Tranquilizers, Department of Pharmacology and Anesthesiology; May 18-20, Physical Examination of the Cardiovascular System, Department of Medicine.

# TOXEMIAS OF PREGNANCY

**T**OXEMIA of pregnancy refers to a variety of conditions occurring in association with pregnancy and often characterized by hypertension. Differences in classification lead to many difficulties in interpreting data from different centers. If a specific cause, whether clinical or humoral, were known for each "toxemic" condition, a sound classification could be made. Even if morphologic distinctions could be made between the different diseases, perhaps on the basis of biopsy of a particular organ, again the different syndromes could be differentiated. However this cannot be done. Therefore, a clinical classification has to be used. The most widely employed is that published by the American Committee on Maternal Welfare in 1952. It is necessarily broad and incomplete, but it limits toxemia to certain specific conditions, whereas in previous classifications such unrelated conditions as hyperemesis gravidarum were included.

## Preeclampsia-Eclampsia

The present discussion will be mainly concerned with the disease classified as acute toxemia of pregnancy or preeclampsia-eclampsia. Under this definition preeclampsia is said to be present if hypertension or edema or albuminuria exist. Hypertension is present if after the 24th week of pregnancy the blood pressure is 140/90 or higher on two occasions at least six hours apart with the patient at rest, or if there is a rise in systolic pressure of 30 mm. of mercury or more or in diastolic pressure of 15 mm. of mercury or more, again with the patient at rest and with two readings obtained six hours apart. Edema is present if the patient has gained five pounds or more in one week and if there is associated edema of the face or hands. Albuminuria is present if a 1+ albumin is detected on a clean catch specimen of urine on two occasions. The original definition required a catheterized specimen, but this appears to be unnecessary at the present time. Preeclampsia is considered to be severe if any one of five symptoms or signs are present—oliguria (400 cc. or less urine output per day), blood pressure 160/110 or higher, albuminuria—5 grams per 24 hours or a 3+ or 4+

Michael Newton, M.D., *Jackson, Mississippi*

## ■ Early therapy may avert the more dangerous manifestations of the disease.

qualitative test, cerebral or visual disturbances, edema of the lungs or cyanosis. Unless one of these is present the disease is considered mild.

Preeclampsia-eclampsia is still a serious hazard to the childbearing woman. Data from a five year study of maternal deaths in Mississippi from 1957 through 1961, indicate that toxemia was responsible for 53 or 29% of 183 direct obstetric deaths. At the University of Mississippi Hospital there were 1,488 cases of preeclampsia-eclampsia among 8,672 deliveries in the four year period from July 1, 1960, through June 30, 1964—an incidence of 17.2%.

Preeclampsia-eclampsia may be conveniently divided into (1) very early disease, (2) well-developed preeclampsia (either mild or severe) and (3) eclampsia.

## Earlier Than Twenty-fourth Week

Although the classification of the American Committee on Maternal Welfare states that preeclampsia can only be diagnosed if the criteria for its diagnosis are present after the 24th week of pregnancy, there is much evidence to indicate that the disease may start earlier than this. For example, Dalton<sup>1</sup> asked 633 women who were between the 16th and 28th week of pregnancy the simple question, "Do you feel as well now as you did before you became pregnant?" and recorded their answers. Twenty-five percent of those who complained of symptoms developed preeclampsia later in pregnancy as compared with only 11% of those who stated that they were feeling well. In a recent analysis of preeclamptic patients, Schewitz, et al.<sup>2</sup> noted that nine out of 77 patients with preeclampsia were at 19 to 28 weeks gestation; in these cases they noted a high incidence of underlying renal vascular disease. In our own institution Fallis and Langford<sup>3</sup> studied

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## **TOXEMIAS OF PREGNANCY / Newton**

the blood pressure of 113 pregnant patients at the 20th to 24th week of pregnancy. They found that the mean blood pressure of those who later developed preeclampsia was significantly higher than the mean blood pressure of those who did not develop this disease. Moreover, if a patient—and the study included only primigravidas, of whom the majority were Negro—demonstrated a blood pressure of over 120 systolic or over 70 diastolic between the 20th and 24th week of pregnancy, she was very likely to develop preeclampsia.

### **Important Points Illustrated**

These observations illustrate several important points. First, preeclampsia, or acute hypertension of pregnancy, probably does start earlier in pregnancy than has commonly been believed. Second, in many such cases there may well be underlying arterial changes. Third, unknown dietary, social or even racial factors may contribute to this underlying arterial change. Fourth, the data obtained at our hospital would indicate the advantage of early treatment of patients with pre-preeclampsia in the hope of preventing the fully-developed disease. Specifically, the use of hydrochlorthiazide in primigravid patients during the last 14 to 18 weeks of pregnancy did result in a significant decrease in the incidence of preeclampsia.<sup>4</sup>

### **Comments Regarding Preeclampsia**

A few comments are in order regarding well-developed preeclampsia—either mild or severe disease. Once the criteria enunciated by the American Committee on Maternal Welfare have been established, hospital admission is indicated. Here the primary objective is to establish a diagnosis and to provide the patient with bed rest. In the mild cases these measures alone will often cause the patient to lose weight and her blood pressure to fall. Where specific therapy is given, it may be administered after the patient has failed to respond to such simple treatment. This therapy includes diuretics, sedatives, anti-convulsants or anti-hypertensives. It is important to recognize, as Mengert and Tweedie<sup>5</sup> have recently shown, that good nursing care without specific treatment is almost as effective as the most potent drugs. However, the final common path of treatment is termination of the pregnancy. At our institution this is usually done if the baby is estimated to be at least 5½ pounds in weight or if the patient is at or beyond the 36th week of pregnancy. Even if the pregnancy is not as far advanced as this, it may often be better for the baby to be in the nursery rather than in the uterus, and labor is therefore often induced in such patients.

Eclampsia represents the most serious aspect of acute hypertension of pregnancy. We have seen 92 patients with eclampsia at the University of Mississippi Hospital from July 1, 1955, when the hospital opened, through December 31, 1964. Of these, 78 occurred before delivery and 14 postpartum. The majority (66%) were primiparas. In view of Griswold and Cavanagh's recent observation that eclampsia appeared to be more common during the hurricane months of August, September and October in Miami,<sup>6</sup> it was of interest to determine the incidence of our cases of eclampsia by months of the year. Although admissions for eclampsia were most frequent in September and October, no significant trend could be detected. While in our hands the maternal mortality was only 2.2% (2 cases out of 92), this is still a considerable risk for the mother, as compared with that for normal obstetrical patients. On the other hand, it is a very grave matter for the baby, since the total perinatal loss in our series was 32%, although many of these deaths occurred before the mother entered the hospital. The fact that eclampsia is associated with poor antepartum care is well illustrated by the observation that in 30 of our 92 cases the amount of antepartum care was unknown (and was probably none or minimal), while in 41 cases the patient had three antepartum visits or less. In only one case did she have ten or more visits to a doctor or clinic.

### **Management of Eclampsia**

In the management of eclampsia, several points may be made. Obviously, treatment must be more intensive than for the preeclamptic patient, but it follows the same lines. The most important factor is that of constant attention by competent personnel. An eclamptic patient is critically ill and must be so managed. Antihypertensives are often indicated. We have frequently used an intravenous infusion of 10 mgs. reserpine and 40 mgs. hydralazine in 1,000 cc. 5% dextrose in water. Excellent results have been achieved by others utilizing other regimens. Magnesium sulfate, in adequate doses, either intramuscularly or intravenously or both, has a less marked hypotensive effect but is a valuable drug to use in the care of the eclamptic patient, particularly as a temporary measure if the patient has to be moved to another center. As in preeclampsia, early delivery of the baby is of great importance. Many of these patients are already in labor when admitted or go into labor promptly. In other cases, it has been our policy to induce labor as soon as the patient's condition has been stabilized. This usually occurs within 24 hours after admission and may be earlier than this. Such a policy of early induction does not result necessarily in more cesarean sections, since our cesarean section rate in eclampsia was only 6.4% as

compared to 6.2% for the service as a whole from 1960-1964 inclusive.

### Summary and Conclusions

1. Acute hypertension of pregnancy (preeclampsia-eclampsia) is a disease which may be very mild or may threaten the life of both mother and baby and may rapidly change from one aspect to the other.

2. Acute hypertension of pregnancy starts early in gestation and can probably be detected before the classical manifestations are apparent. Specifically, a blood pressure of over 120 systolic or over 70 diastolic at 20 to 24 weeks of pregnancy may be a warning sign. When detected early, preventive treatment, such as by diuretics, is likely to avert the more dangerous manifestations of the disease.

3. Acute hypertension of pregnancy is only one of a number of conditions which are related to gestation and which have similar characteristics. Much more information is needed regarding the exact causes of these disorders. Until that time a working classification is needed, based on clinical considerations, which covers the syndromes found and which can be used effectively. That proposed by the American Committee on Maternal Welfare has proved to be very valuable. Newer knowledge of the factors underlying hypertensive disease in pregnancy will

probably soon indicate changes in the classification of these disorders.

4. While waiting for more precise information on the nature of the hypertensive disorders of pregnancy, it is essential to maintain sound principles of management when well-defined disease is present. These include prompt hospitalization of the preeclamptic patient, primary treatment by bed rest with the use of appropriate drugs as indicated and early induction of labor. The worst manifestation of acute hypertension of pregnancy—eclampsia—requires constant skillful nursing care and intensification of measures used in the management of preeclampsia. In this way maternal mortality can be kept at a low level, but perinatal mortality still remains a serious problem.

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*University of Mississippi School of Medicine*

## "CIRCUIT COURSE" POSTGRADUATE EDUCATION CONTINUES THROUGH MAY

The 1965-1966 Georgia "Circuit Courses," sponsored by the Medical Education Board of the Medical Association of Georgia, and the Medical College of Georgia, Augusta, will continue through May as follows:

### Waycross/Memorial Hospital

February 1—Optic, Neurological and Medical Disorders

March 1—Problems in Reproductivity and Infant Care

March 29—Cardiovascular Disease

April 26—Renal and Urinary Tract Diseases

### Moultrie/Colquitt Hotel

February 2—Optic, Neurological and Medical Disorders

March 2—Problems in Reproductivity and Infant Care

March 30—Cardiovascular Disease

April 27—Renal and Urinary Tract Diseases

### Dublin/VA Center Hospital

February 3—Optic, Neurological and Medical Disorders

March 3—Problems in Reproductivity and Infant Care

March 31—Cardiovascular Disease

April 28—Renal and Urinary Tract Diseases

### Toccoa/Georgia Baptist Assembly Grounds

February 15—Care of the Acutely Injured Patient

March 15—Renal and Urinary Tract Diseases

April 12—Optic, Neurological and Medical Disorders

May 10—Arthritis

### Dalton/Hamilton Memorial Hospital

February 16—Care of the Acutely Injured Patient

March 16—Renal and Urinary Tract Diseases

April 13—Optic, Neurological and Medical Disorders

May 11—Arthritis

### Thomaston/Upson County Health Building

February 17—Care of the Acutely Injured Patient

March 17—Renal and Urinary Tract Diseases

April 14—Optic, Neurological and Medical Disorders

May 12—Arthritis



# BLURRED VISION AND SYSTEMIC MEDICATION

P. Thomas Manchester, Jr., M.D., *Atlanta*

## ■ Blurring may be an indication for discontinuation of therapy.

THE TERM "iatrogenic" is heard more and more at medical meetings and during informal discussions. Even in ophthalmology we are becoming aware of many adverse effects on the eyes of patients who are receiving systemic medicines for disease elsewhere in the body.

### Familiar Effects

Some drugs have been long recognized in their association with ocular symptoms. The visual hallucinations and xanthopsia of overdigitalization are quite familiar. The blurred vision from cholinergic blocking agents such as atropine and probanthine are also well known. Because of their cycloplegic effect these drugs often cause signs of early presbyopia in patients under medication for peptic ulcer. Glaucoma is sometimes precipitated by these same drugs.

Most of the time the ocular complications of systemic medicines are not specific, and the association between the two is vague and indefinite. Often the patient is taking more than one drug and sometimes his general health is too poor for a vital drug to be discontinued. To make matters worse, there may be no improvement in vision after the drug is stopped, leaving us without proof that there was any connection between the blurred vision and the particular drug which is under consideration.

### Retinopathy

The sedative thioridazine (Mellaril®) sometimes produces pigmentary degeneration of the retina with night blindness. There is narrowing of retinal arteries and scattered pigment clumps resembling retinitis pigmentosa. In this instance, the damage to the vision seems to be irreversible, despite the discontinuance of the drug. However, tragedy and liability come from the failure to recognize the cause of the visual

defect early because the longer the drug is given, in this situation, the more severe will be the blindness.

Chloroquine (Aralin®) and hydroxychloroquine (Plaquenil®) which are most effective in the treatment of lupus erythematosus and arthritis, have been found to cause a serous retinopathy with marked loss of central vision and defective visual fields. In addition, corneal infiltrates develop. Unfortunately, these drugs are retained in the body and they may cause progressive retinal degeneration even after the cessation of therapy.

Pigmentary degeneration of the retina is not always the result of genetic factors. Certain drugs can produce retinal changes which are almost indistinguishable from the familiar retinitis pigmentosa. This is particularly true of the phenothiazine drugs which have variable effects as tranquilizers, antihelminthics, and insecticides.<sup>1</sup>

### Impaired Circulation

Many older patients who have macular degeneration of the retina are on drugs for hypertension. If the systolic blood pressure is kept at a level of about 120 mm. of mercury, the patient may not be able to read his newspaper. When the drug dosage is reduced and the blood pressure is allowed to rise to 160, or thereabouts, the vision will improve so that he will be able to read because of the increased blood flow to the retina.

### Diplopia

Recently a young woman was seen in consultation because of blurred vision due to diplopia. When looking in the field of action of the lateral rectus muscles, it was evident that they were paretic. The diplopia varied in amount from day to day. She had been taking diphenylhydantoin (Dilantin®) for epilepsy. Because of the possibility of brain tumor, cere-

bral arteriograms and ventriculograms were being considered. However, the visual symptoms subsided when the drug was stopped.

Certain drugs cause blurred vision which is actually diplopia due to paresis of ocular muscles. This occurs with phenothiazines, dilantin, altafur, and various tranquilizers. This effect is sometimes seen at cocktail parties. A few drinks regularly cause some guests to develop a deviation of one eye. This may serve as a sign to the patient (or his spouse!) that he has reached the saturation point of alcohol consumption.

### Hemorrhage

If a patient has a tear of the retina, a trace of blood may escape into the vitreous. Serious attention must be given to the cessation of any systemic medication such as heparin or bishydroxycoumarin (Dicumerol®), for in this patient it might cause a massive vitreous hemorrhage and resultant blindness.

### Glaucoma

Cortisone drugs are the cause of several serious ocular disorders. A simple, mild dendritic ulcer of the cornea may be changed into a chronic progressive disease which produces blindness or even loss of an eye, because of medication with systemic cortisone. A seemingly normal eye may develop glaucoma when cortisone reduces the facility of aqueous outflow.

### Cataracts

Cortisone drugs cause cataracts. The longer the hormones are used, the greater is the likelihood of cataracts developing. The duration of treatment and the steroid dose are additive factors in the production of lenticular opacities.

When ocular surgery is being considered the systemic corticosteroids should be stopped, for they reduce the resistance to infection. Zimmerman has shown that ocular infection is enhanced by the giving of these drugs. This is particularly true in regard to fungus infections which cause catastrophic infections in the eye.<sup>2</sup>

### Optic Neuritis

Although optic neuritis and toxic amblyopia in themselves are rare, they can be produced by many systemic drugs. The principal drugs implicated are those used in tuberculosis in addition to streptomycin and the sulfonamides. Toxic amblyopia is a vague term used for blurred vision, centrocecal scotomas, and no objective signs. Tolbutamide (Orinase®) and acetazolamide (Diamox®) seem to be implicated in some cases of toxic amblyopia. They should be discontinued if a diabetic patient develops poor vision or visual field defects shortly after starting one of these drugs.

### CHART

#### EYE SIGNS AND THE DRUGS WHICH MAY PRODUCE THEM

Eye Signs	Most Likely Culprit
Corneal Infiltrates .....	Chlorpromazine (Thorazine®) Chloroquine (Aralin®) Hydroxychloroquine (Plaquenil®)
Cataracts .....	Corticosteroids, chlorpromazine (Thorazine®)
Pupils Dilated .....	Anti-cholinergic drugs (Atropine®, Probanthine®)
Pupils Constricted .....	Morphine, cholinergic drugs
Optic Neuritis and Optic Atrophy .....	Sulfonamides, Chloramphenicol, Isoniazid, Chelating agents, M.A.O. inhibitors, Antimalarials, Chlorpropamide (Diabenese®), Tolbutamide (Orinase®)
Glaucoma .....	Anti-cholinergic drugs, Penicillamine, Alpha Chymotrypsin, Corticosteroids
Diplopia .....	Tranquilizers, anticonvulsants
Retinal Degeneration .....	Chloroquine (Aralin®), Hydroxychloroquine (Plaquenil®), Phenothiazines (Thorazine®) Phenergan, Pacatal, Dartal, Stelazine, Compazine, Trilifon, Vesprin, Sparene, Vontil, Temaril, Thioridazine (Mellaril®), Torecan
Acute Myopia .....	Prochlorperazine (Compazine®), Sulfonamides, acetazolamide (Diamox®)
Disturbed Color Vision .....	Iproniazid (Marsilid®)
Xerophthalmia ("dry eyes") ..	Muscle relaxants (Norflex®) Antihistamines (Benadryl®) Tranquilizers (Compazine®, Sparine®), Antispasmodics (Atropine®, Banthine®), Somnolents (Nytol®) <sup>3</sup>
Choked Discs .....	Oral contraceptives <sup>4</sup>

The above Chart indicates specific eye signs which may be found in the patient who complains of poor vision. It also lists the drugs most likely to cause these signs.

### Conclusions

Many drugs cause blurred vision when given systemically. Sometimes it is imperative that the drugs be stopped in order to avoid harm to the eyes.

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478 Peachtree Street, N.E.



# WHAT IS THE FUNCTION OF AN INVESTMENT COUNSELOR?

John N. Wall, Jr., *Atlanta*

**E**DITOR'S NOTE: *In an endeavor to familiarize the physician with the functions of an "Investment Counselor," we have asked an authority in the field to prepare a question and answer type interview on this subject. The author, a partner in the Investment Counsel firm of Montag & Caldwell, Atlanta, has written the following interview between a physician and an investment counselor.*

**Dr.—**Just how to accumulate a retirement fund is a problem most of us doctors give a lot of thought to. Many publications aimed at physicians point out investment counsel as being one answer to this problem. But these articles are rather general in nature. Can you tell me how you, as an investment counsel, would work with me as a client and just what I could expect from using your service?

**I.C.—**Accumulating a retirement fund is a problem facing a lot of us, Doctor, including most investment counsels. Our first visit with you after you had decided on retaining an investment counsel would be like your first visit with a new patient. We have a printed form to fill in with pertinent information about you and your financial fitness; much like the initial record you would take on a patient and his health. We treat this information confidentially just as you treat yours.

**Dr.—**What sort of information would you want?

**I.C.—**As much about your total financial picture as possible. While we would advise you specifically about your securities, it is helpful for us to be familiar with your personal situation. Such things as income from practice, income from other sources, what are these sources, life insurance coverage, money owed and other obligations, and tax bracket. We would also want to know your family situation, and just what it is you expect and want from your security investments.

**Dr.—**Is it necessary to have all that information to make money in the market?

**I.C.—**Probably not—but the information is helpful in doing a thorough job for you. We sometimes use an analogy of a patient who visits a doctor with a swollen finger. In order to do a good job the doctor is going to have to examine more than just the patient's finger. In order to build a securities portfolio which will perform satisfactorily for the doctor, the advisor needs to know how this fits into the doctor's total financial picture.

Many individuals have assets other than securities, such as a home, other real estate, interests in businesses, mortgages. All of these have varying degrees of risk. All these risks should be weighed in determining the ability of an individual to take on additional risks.

**Dr.—**In other words, the better you know a patient—excuse me, client, the better job you can do.

**I.C.—**Exactly, and this is where investment counsel differs from other sources of investment advice. Our service is as personal as we can make it. We want to know the client well and we want to build his investments so that they specifically suit his personal needs.

**Dr.—**What follows after the decision has been reached to employ investment counsel, and you have the information you need?

**I.C.—**We would also need a list of your securities showing their cost basis and dates of acquisition. We would also want to discuss with you what you should expect from security investments. Unfortunately, investing is not nearly the science that medicine is and investment counsels are far from miracle workers.

**Dr.—**Can you tell me what I should expect from security investments managed by an investment counsel?

**I.C.—**A better performance than you would probably be able to achieve on your own—unless you were neglecting your practice. I assume that you would be interested in growth of principal rather than current income since you expressed a desire to



build a retirement fund. Once you have retired you can change your investment objectives to emphasize current income. First, let me say what you could not expect. That would be a spectacular performance such as a doubling of principal in a short period of time. If this were so, we wouldn't need clients.

You could expect a soundly based program which would give you steady growth over the years. We operate in a market which is constantly changing. During "bear" markets, when stocks are under pressure, your stocks would go down too. During good markets you could expect your securities to move ahead at a rate somewhat better than the popular averages. In the past this has averaged somewhat better than 10% for our clients. As to what the future will bring, it's impossible to be exact. However, we have great faith in our economy and its dynamism and believe that there are many good profits to be had in the years ahead.

**Dr.—Do you take possession of my securities?**

I.C.—No, the securities can be left in your safe deposit box or placed in a custodian account either with a bank or a reputable broker. The custodian account would relieve you of trips to your box when changes are made.

**Dr.—Would there be many changes?**

I.C.—If you mean would we be trading your account the answer is no. Initially, there might be more changes than usual, as we move you into certain securities which we feel are more suitable for you than some you already hold. Once this "shakedown" is completed changes would not be that frequent.

We take a long-range attitude toward our stock commitments. These stocks have been thoroughly researched and we feel they are the sort of companies we want to be partners in. We find that really sizeable capital gains accrue through the years—much greater than can be had by scalping a few points here and a few points there. The broker makes more this way than the client.

**Dr.—How frequent and what sort of contact would I have with my counsel?**

I.C.—He would be available at any time you wanted to talk with him. Since close and personal service is the hallmark of this business, each of us looks after only about 50 portfolios. This way we can know these portfolios and the people well and be sensitive to needed changes.

Each quarter you would receive a summary of your holdings showing current valuations, expected income for the next 12 months, and percentage investments in different types of securities. Your port-

folio would be reviewed often to see that it continues to meet your objectives and you would receive letters periodically from your counsel discussing the economic outlook and how this relates to your present investment. Any time a specific change is required you will be contacted by phone or a letter explaining the recommended change. In other words, we follow your investments very closely checking often on the progress of the companies represented and try to take timely action when it is called for.

**Dr.—If, after digesting the reasons for the recommended changes, I approve the changes, what course would I follow?**

I.C.—One of two courses. You could execute the transactions yourself or you could sign an approval of the recommendations, return it to your investment counsel, and he would be glad to execute the transactions. So that we were able to keep track of your holdings accurately, we would want to receive duplicate invoices from your broker whether you placed the orders or we did.

**Dr.—May I continue to use my own broker?**

I.C.—Certainly. If there are special situations where you could save some money by using another broker in that particular instance, we would feel remiss if we didn't point that out. However, I would say you can use your broker 99% of the time.

**Dr.—If I had a question regarding any of my holdings, would it be welcome?**

I.C.—It most certainly would be welcome. One of our main jobs is to make clients feel comfortable and secure with their investments. Some people are more temperamentally suited to security investments than others. Common stocks, particularly, by their nature and the nature of the markets in which they trade, fluctuate quite widely. Since they are quoted each day in the paper a client can follow their progress closely. The less sophisticated can get upset if a drop of a point or two occurs, and it is our job to reassure them. You know real estate fluctuates in value too. It simply isn't quoted daily in the paper.

We like to meet personally with our clients periodically to discuss their securities and to see if any changes have occurred in their personal situation which would alter their investment program.

**Dr.—How does an Investment Counsel charge for his services?**

I.C.—Most Investment Counsels annually charge a percentage of the principal amount of money under their supervision. This charge averages about one-half of one percent.



## INVESTMENT COUNSEL / Wall

If the portfolio goes up in value the fee is larger because of the increased amount of funds under supervision. If it goes down in value, the fee is smaller as the funds have shrunk.

We feel that this means of charging makes our interest identical with the client's.

The fee is a tax deductible item so the net out-of-pocket expense is really considerably less.

**Dr.—I see. So to wrap it all up, Investment Counsel provides a personal and continuing ser-**

**vice which has successfully helped individuals accumulate sizeable funds. No get-rich-quick schemes, no crystal balls, just unbiased, thoroughly considered advice which in the past has produced successful investment results.**

**I.C.—I couldn't have said it better myself.**

**Dr.—Thank you. I appreciate your time.**

**I.C.—Thank you. We welcome every opportunity to tell more people what an Investment Counsel is and does.**

*1100-13 First National Bank Building*

## 1966 CALENDAR OF MEETINGS

### State

Postgraduate Courses sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.

January 12-March 30—Psychosomatic Medicine follow-up course (12 weekly evening sessions).

January 18-19—Common Metabolic Disorders

January 25-26—Pediatrics

February 22-23—Obstetrics and Gynecology

March 10—The Adolescent Girl

March 24-25—Trauma

December 7-May 12—Georgia Circuit Courses (six sessions, one day each month at six centers in Georgia).

February 5-6—MAG Annual County Society Officers' Conference, Marriott Motor Hotel, Atlanta.

February 21-25 (to be repeated April 18-22)—"A Short Course in the Administration of Nursing Service in Nursing Homes," sponsored by the School of Nursing, Medical College of Georgia at the Fulton County Department of Health, 99 Butler St., S.E., Atlanta.

February 28-March 3—Southeastern Surgical Congress, Marriott Motor Hotel, Atlanta.

March 3—"A Short Course in Proctosigmoidoscopy" sponsored by the Department of Surgery, Emory University School of Medicine, in conjunction with the American Cancer Society, Grady Hospital Auditorium, Atlanta.

March 15-19—Postgraduate Seminar in "Fundamentals of Otolaryngologic Allergy," sponsored by the University of Tennessee College of Medicine, Memphis, Tenn.

March 16-18—A Symposium on "Clinical Aspects of Renal-Endocrine Interactions," presented by the Department of Medicine, Emory University School of Medicine, Grady Hospital Auditorium, Atlanta, Ga.

April 4-8—39th Annual Spring Congress in Ophthalmology and Otolaryngology sponsored by The Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.

April 12—1966 Paramedical Personnel Symposia to be held simultaneously in the following ten Georgia cities: Albany, Atlanta, Augusta, Columbus, Dublin, Gainesville, Macon, Rome, Savannah, and Waycross. The Symposia are co-sponsored by the Georgia Heart Association, Georgia State League for Nursing, Georgia Society of Medical Technologists, Georgia Dietetic Association, and the Georgia State Nurses Association.

April 11-16—"Workshop in Radioisotope Scanning," Emory University School of Medicine, Atlanta.

April 13-16—19th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Va.

April 14-16—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, Grand Bahama Hotel, Grand Bahama Island.

May 5-7—Ninth Biennial Cardiovascular Seminar, "Newer Methods in Ischemic Heart Disease," presented by the Section of Cardiology, University of Miami School of Medicine and the Heart Association of Greater Miami, Carillon Hotel, Miami Beach, Fla.

May 8-10—112th Annual Session of the Medical Association of Georgia, Columbus, Ga.

### Regional

September 15, 1965-June 15, 1966—A nine month tutorial program in Cardiology offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

January 16-22—Postgraduate Medical Education, "General Practice Review," sponsored by the University of Colorado School of Medicine, Denver, Colo.

January 28-30—Southern Radiological Conference, Grand Hotel, Point Clear, Fla.

January 31-February 2—American College of Surgeons Sectional Meeting, Houston, Tex.

February 7-9—Atlanta Graduate Medical Assembly, Marriott Motor Hotel, Atlanta.

February 28-March 3—Southeastern Surgical Congress, Marriott Motor Hotel, Atlanta, Ga.

February 28-March 4—Seminar in Obstetrics and Gynecology. Cruise to Nassau and Freeport in the Bahamas, S.S. *Ariadne*. Sailing from Ft. Lauderdale, Fla. Presented by the Dept. of Obstetrics and Gynecology, College of Medicine, University of Florida. Approved by Florida State Board of Health, Florida Medical Association, and Florida Academy of General Practice.

March 7-10—New Orleans Graduate Medical Assembly (29th Annual), The Roosevelt Hotel, New Orleans, La.

March 21-23—Dallas Southern Clinical Society, Statler-Hilton Hotel, Dallas, Tex.

### National

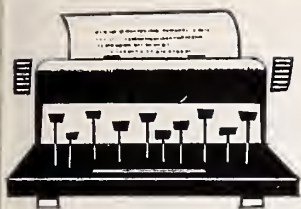
February 27-March 4—International Anesthesia Research Society (40th Congress), Americana Hotel, Bal Harbour, Fla.

March 23-25—American Surgical Association, Boca Raton, Hotel, Boca Raton, Fla.

May 23-25—Annual Meeting of the American Thoracic Society, Medical Section of the National Tuberculosis Association, San Francisco, Calif.

June 26-30—American Medical Association Annual Convention, Chicago.





## The Intrauterine Contraceptive Device in Private Practice

**N**O MEDICAL TOPIC in recent history has so captured the public interest as that of contraception. Awareness of effective, inexpensive methods of preventing pregnancy is the natural result of this fascination. During the past decade the oral contraceptives were added to the more conventional, mechanical techniques. With this advent, the use of all methods expanded rapidly and the search for better forms continued.

### Motivation

Although not new, the use of foreign bodies placed within the uterine cavity is attracting increasing attention. This concept offers many advantages not enjoyed by the oral contraceptives. Most outstanding is the lack of continued motivation necessary on the part of the patient. In other words, only one decision is needed. Once this is made and the device inserted, pregnancy is very unlikely until this foreign body falls out or is removed. This feature makes it a particularly effective system in mass population control where any significant reduction in the birth rate is desirable.

Certain factors in the use of the Intrauterine Contraceptive Devices are of particular interest for the private patient and her physician. It is the purpose of this communication to focus upon these.

### Effectiveness

Of primary importance to most women seeking contraceptive advice is the question of effectiveness. She can be told with confidence that the properly placed IUCD is associated with a pregnancy rate of only about 1-2%. This compares quite favorably with the rate of 10-15% most frequently reported during the use of the vaginal diaphragm, condom, spermicidal jellies, foams, or combinations thereof. To some, even this low rate may seem large when compared to the oral contraceptive. A vast experience with these hormones has proven, beyond doubt, that they are the most effective method yet devised of temporarily preventing pregnancy. An exception to this may exist with use of the newer sequential forms. Hormonal contraception is not without side effects and serious question of its universal safety has been raised.

### Selection of Patients

Not every patient is a candidate for the IUCD. The most specific contraindications are existing pregnancy, active pelvic inflammatory disease, submucous myomata, and menstrual disorders. While possible, the introduction of devices in the nulliparous patient may be difficult and is often painful. Another possible contraindication is the concurrent use of the oral contraceptives. This combination reportedly predisposes to problems of menstrual flow. The ideal subject is the young multipara with frequent pregnancies who is convinced that her family should not enlarge.

Side effects are not rare with the IUCD and their possibility should be recognized by both the patient and her physician.

There are three general problems which sometimes follow the *proper* placement of an IUCD.

### Problems

Menstrual disorders, while usually transient, include menorrhagia, metrorrhagia, intermenstrual spotting, and dysmenorrhea. All of these tend to disappear after several months of use. Their likelihood is reduced if the previously mentioned contraindications are adhered to.

Every large series has included an occasional case of pelvic inflammatory disease appearing after the placement of a device. Since careful histologic and bacteriologic study has failed to show that infections are actually caused by the IUCD, they may usually be left in place. Antibiotics most often effect a cure. This possibility of infection and subsequent sterility is probably less likely in the private patient than in the indigent.

### Pregnancy Possible

Pregnancy may occur, even in the presence of a properly placed device. In this unlikely event, the foreign body need not be removed. Although the likelihood of miscarriage is greater than usual, careful study of these offspring has failed to suggest any

connected fetal abnormalities. Most pregnancies follow unrecognized expulsion of the device. This is especially likely during the first few months of use. Therefore, the ideal device must include some means of self examination. This necessity is often overlooked by the uninformed candidate.

In addition to these side effects there is the hazard of improper placement of the device outside the uterine cavity. This may result in perforation of the uterine wall and injury to the abdominal viscera. It is important, therefore, that insertion be performed by a competent, experienced operator.

### Advantages

Ease of insertion and the low cost of the devices are the greatest assets of this system. When first introduced over 30 years ago, inert metals were used. These were not only expensive but impossible to introduce through the undilated cervix. With the recent availability of flexible plastics, a variety of sizes and shapes have appeared (See Cover).

### Types of Devices

Four types are most commonly used. The spiral (Marguilies), and the loop (Lippes) enjoy the greatest popularity. Both allow self-examination and easy removal. Application can be made without anesthesia or cervical dilatation. The spiral includes a beaded stem which projects to the external cervical os to be palpated by the patient—and unfortunately, occasionally felt by the husband. Two small threads attached to the Lippes Loop extend into the vagina where they are easily identified. Bow-tie shapes (Birnberg) and coiled steel rings (Hall) have also been used extensively.

Each shape and structure has advantages and disadvantages. Some have a higher expulsion and pregnancy rate. Others are more often associated with uterine perforation. A search for the perfect form and material continues.

### Mode of Action

How pregnancy is prevented is not yet known. Excessive tubal peristalsis resulting from the irritated uterus is the most likely explanation. Thus the ovum is propelled too quickly beyond the normal site for fertilization. That fertilization does occasionally occur in spite of this gives rise to the suggestion that the IUCD may sometimes act as an abortive agent. This possibility is, incidentally, shared by the oral contraceptives.

Serious moral questions may be raised for both the patient and her physician in selecting any artificial contraceptive measure. This is particularly true when the exact mode of action is unknown.

### Large Population Groups

Without doubt the intrauterine contraceptive device is the most reliable system yet applied to large population groups. Ease of application, low cost, and patient acceptance are great advantages. That this method can safely and effectively be employed is well demonstrated in such excellent projects as that now in progress at The Grady Memorial Hospital. Under the supervision of the Department of Gynecology and Obstetrics of the Emory University, over 4,000 devices have been inserted. A vast reduction in the number of unplanned pregnancies in these patients is certain. The obstetric hazards which these patients would otherwise face far outweigh the occasional side effect or accident.

Special considerations must be faced, however, by the private physician recommending the IUCD. Outstanding among these is the lack of legal and ethical tradition referable to this subject. Until very recently, any intrauterine foreign body was looked on as a hazard. This prejudice has not yet been overcome in spite of vast and impressive current experience.

Not every woman who selects this method will succeed in its use. Only about 80% continue through the first year. Some cannot tolerate the additional discomfort, others the menstrual changes. Still others may expel the device. In each of these areas the private patient is more apt to demand an accounting than the indigent clinic patient.

In conclusion, the intrauterine contraceptive devices are safely effective in preventing pregnancy in most women. Some factors in their use require special attention for the private practitioner. Because of the low incidence of serious side effects and the high degree of patient-acceptance their use will increase rapidly. Soon this may equal that of the oral contraceptives.

As man expands his mastery over the forces of nature it is well to pause occasionally to reflect on his wisdom in the use of this power. On every hand we are bombarded with the dangers of uncontrolled population expansion, unwanted births, and other dire consequences of pregnancy. Against this effort to prevent pregnancy should be balanced encouragement for those able to produce useful citizens. In this regard we may find ourselves too ready to apply the brakes but reluctant to use the accelerator.

*Earnest M. Curtis, M.D.  
1938 Peachtree Road, N.W.  
Atlanta, Georgia.*



# “Heart Disease, Cancer and Stroke” Enacted With Changes

**S**ECOND only to “medicare,” the most widely known and discussed piece of medical legislation to emerge from the first session of the 89th Congress was a bill known as the “Heart Disease, Cancer and Stroke Amendments of 1965.” Enacted during the dying days of the last session of Congress, this bill has now become Public Law 89-239. The following is an analysis of the provisions of this Act:

## Purpose

The purpose of this law is to authorize the Surgeon General to encourage, through financial grants, in the establishment of regional cooperative arrangements among medical schools, research institutions and hospitals for research, training, and demonstrations of patient care in the fields of heart disease, cancer, stroke and related diseases. And further, to afford the medical profession and medical institutions, through cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases.

## Appropriations

The law authorizes the appropriation of \$340 million over the three fiscal years of 1966-67-68. This money would be used for grants to assist public or non-profit private universities, medical schools, research centers and other public or non-profit private institutions in (1) planning, (2) conducting feasibility studies, and (3) operating pilot projects for the establishment of regional medical programs of research, training and demonstration activities.

The law specifically states that appropriated funds will not be available to pay the cost of hospital, medical, or other care of patients except for the purposes of research, training or demonstration activities which meet the purposes for which the law was intended. Further the law provides that no patient may be furnished hospital, medical or other care at any facility under this program unless he has been referred to the facility by a practicing physician.

The Surgeon General is authorized to make money grants to private or non-profit institutions and agencies only when such a grant has been recommended to him by the National Advisory Council on Regional Medical Programs. This Council will be composed of 12 persons, two of whom must be practicing physicians who are recognized as outstanding in the fields of heart disease, cancer and stroke. In addition to the National Advisory Council, the law stipulates that grant applications may be approved only if they have been recommended by a local advisory group.

## Definitions Under the Act

For the purposes of this law the following definitions are important.

A “regional medical center” means a cooperative arrangement among a group of public or non-profit institutions engaged in research, training, diagnosis, and treatment relating to heart disease, cancer, stroke or a related disease if the center: (1) is located in a geographic area appropriate to carrying out the intent of the law; (2) is comprised of one or more medical centers, one or more clinical research centers, and one or more hospitals; and (3) has in effect cooperative arrangements among its component parts.

A “medical center” means a medical school or other institution involved in postgraduate medical training, or a hospital(s) affiliated therewith for teaching, research and demonstration purposes.

A “clinical research center” means an institution primarily engaged in research, training of specialists, and demonstrations, and one which provides high quality diagnostic and treatment services to both in-patients and outpatients.

## Listing of Centers

Under this Act, the Surgeon General is required to maintain an up-to-date listing of facilities throughout the country which are equipped and staffed to provide the most advanced methods and techniques in the diagnosis and treatment of heart disease, cancer and stroke.

More than 17,300 Georgians are currently being treated for cancer. New methods of treatment and diagnosis have improved the cancer cure rate over the last

25 years and today, one in three cancer patients is being saved. Half could be saved with earlier treatment.



Flagyl destroys trichomonads



No topical treatment can



**Flagyl**<sup>®</sup>  
brand of  
metronidazole

Flagyl eliminates the difficulties and frustrations that have long attended the treatment of trichomonal infection.

These difficulties arose mainly from:

- 1) *the failure of any previously known agent to destroy the protozoan in para-vaginal crypts and glands;*
- 2) *the failure of any previously known agent to prevent reinfection by eradicating the disease in male consorts.*

The introduction of Flagyl removed both of these long-standing deficiencies. Hundreds of published investigations in thousands of patients have confirmed the ability of Flagyl to cure trichomoniasis.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced a cure rate of up to 100 per cent in large series of patients.

Nothing cures trichomoniasis like Flagyl.

### **Dosage and Administration**

*In women:* one 250-mg. oral tablet t.i.d. for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.

*In men:* in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

### **Contraindications**

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

### **Precautions and Side Effects**

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

### **Dosage Forms**

Oral—250-mg. tablets/Vaginal—500-mg. inserts

**SEARLE**

*Research in the Service of Medicine*



## CONFERENCES AND THE PRESIDENT'S LETTER

**T**HIS is no complaint, but recently it has seemed that the deadline for a President's Letter and a conference or meeting of some type have had a habit of occurring simultaneously. This has meant that it has been necessary to move that deadline forward in order not to be behind the "eight ball" upon the return home. Is that good? I think so, because upon the return from a meeting, subject matter is available for another letter. Maybe you don't like to read about meetings though!

The latest meeting came about when "out of the blue" there was an engraved Presidential Invitation, of short notice, to attend the White House Conference on Health on November 3 and 4.

### An Interesting Experience

This conference was a most interesting experience. It turned out to have between 700 and 800 participants, plus officials, staff, observers and press representatives.

On the morning of the 3rd, the Conference opened with a general session at which two to three speakers were heard. Following this, the Conference split up into six panel sessions. The same type program was held that afternoon and again the following morning. At lunch on both days we had big name speakers from the cabinet level and medical areas—such as Dr. J. Z. Appel, AMA President, and Dr. Marcolino G. Candau, Director General of the World Health Organization.

The cabinet level speakers included Secretary of State Dean Rusk, Secretary Gardner of HEW, and the new Surgeon General, Stewart.

At one time or another, nine cabinet members either spoke or were on the platform at one of the general sessions or at lunch time. Had he been able, I am sure the President would have been there.

The final afternoon was given over to a conference summary, which is to be made available to President Johnson at an early date. A complete transcript of the conference will be published later and sent to all the conference participants.

### Well Represented

Georgia was well represented at the conference. According to my count, there were nine Georgians (residents) among the participants. There were four native Georgians, who now live elsewhere, who were platform participants, plus one who was a featured panel speaker.

One of my panel assignments was on the panel concerned with "Trends in Continuing Medical Education." At this time, I was recognized and told of our January, 1965 Conference on Medical Education and the resultant "Circuit Riding" courses being provided by the faculty of the Medical College of Georgia under their sponsorship, and that of the Medical Association of Georgia and the Georgia Academy of General Practice.

The final event of the conference was the White House Reception held at 5 p.m. on the 4th. This was a very delightful occasion, which provided an opportunity to get a good look at the White House where we stayed approximately one hour and a half. Vice President Humphrey and Mrs. Humphrey served as hosts in the absence of the President and Mrs. Johnson.

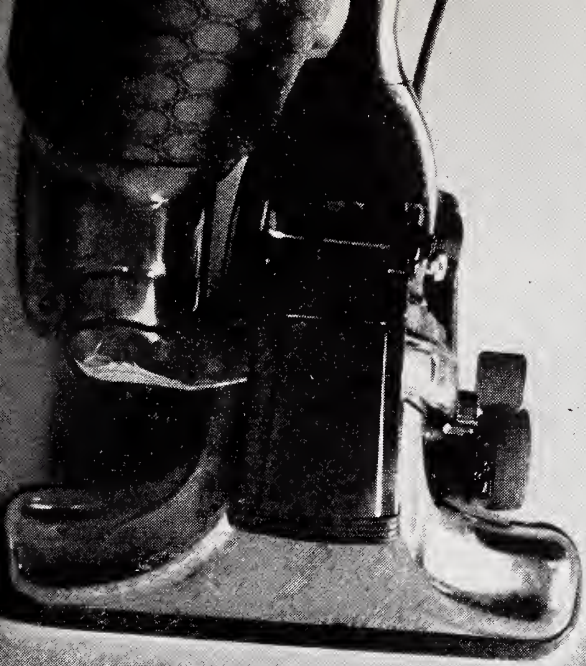
For what they are worth, my impressions of the conference are:

1. Of the 700 to 800 participants, I would estimate the number of private practicing physicians at about 100. I counted 19 State Medical Society Presidents as present, according to the last available registration roster.
2. No conclusions or recommendations were presented. Nothing was brought up for a vote.
3. A summary is being prepared for presentation to the President. This is to be followed by publication of a complete transcript of the conference.
4. From the above, I believe it is likely that recommendations for legislation will be forthcoming. These recommendations could involve:
  - a. Health manpower needs.
  - b. Medical education—both basic and continuing, and also education of allied health professions.
  - c. Community planning.
  - d. Consumer protection.
  - e. Accident prevention.
  - f. Air and water pollution.

We need to be prepared to evaluate such recommendations in order to know whether to support or oppose. It would be better still to be able to initiate proposals when we feel strongly that we should.

George H. Alexander, M.D.  
President, Medical Association of Georgia





ANY  
VACUUM  
CLEANER  
CLEANS  
RUGS,  
FURNITURE  
AND DRAPES



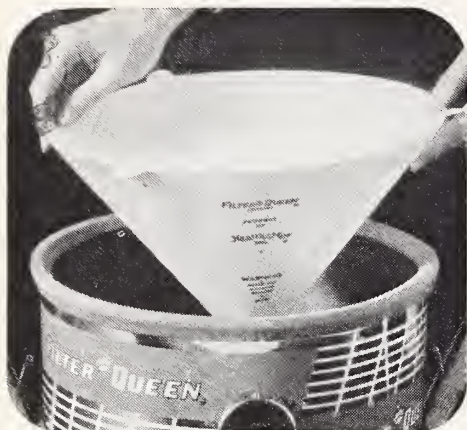
Only  
*Filter Queen*  
cleans the  
air, too!



*Proof? See inside—*



# DRAMATIC TEST PROVES FILTER QUEEN TRAP



**1** Place a fresh Sanitary Filter Cone in the FILTER QUEEN container. (It takes only a moment to open the machine and replace the old Filter Cone.)



**2** Now unfold a clean white handkerchief and drop it into the Sanitary Filter Cone. (Even the daintiest, sheerest handkerchief may be used with perfect safety.) Then replace the turret top on the container.



**3** Now turn the machine over to any one witnessing the demonstration, and have her start the machine and apply the nozzle to any place where there is obvious dirt and dust. Keep the machine operating for a full minute.

## *See the proof with the* **FILTER QUEEN** *“clean handkerchief”* *test*

**4** Remove the top of the container, and lift out the handkerchief. You'll find it spotless as it was when it went in! (Where did the dirt go? Look in the bottom of the container.)



**NO DUST ON  
HANDKERCHIEF**

**filter traps dirt  
in container**



# DUST AS NO "VACUUM CLEANER" CAN!

*Revolutionary...and in a class by itself!*

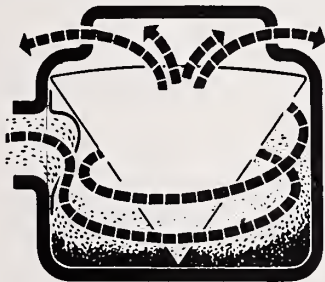
## **FILTER QUEEN**

*has the scientific cleaning features that hospitals need most*

All "vacuum" cleaners were much the same until the FILTER QUEEN SANITATION SYSTEM was designed. FILTER QUEEN'S patented Sanitary Filter Cone eliminates the need for messy bags, traps practically all airborne contaminants passing into the machine (Harvard Medical School Report in Journal of the American Medical Association, November 25, 1958).\*

Experienced hospital housekeepers know this well. That is why FILTER QUEENS have replaced every type of vacuum cleaner in hundreds of hospitals throughout the world.

FILTER QUEEN has no porous bag that permits dust and dirt to reenter the room. FILTER QUEEN operates on an entirely different principle, "Cyclonic Cleaning Action." Here's how it works: Inrushing air, laden with dirt and dust, is deflected by a patented inlet guide as it enters the



container; then is whirled by centrifugal force away from the cone. Dust and dirt are dropped to the bottom of the container. (See illustration.) Air, being lighter, is funnelled to the center of the "cyclone," filters through the Sanitary Filter Cone and returns to the room dust-free.

Why not ask your local FILTER QUEEN Distributor to make the dramatic handkerchief test (pictured at left) in your hospital? There is no better way to prove the improvement in cleaning ability between a FILTER QUEEN SANITATION SYSTEM and any type of vacuum cleaner. (You'll find your distributor listed in the Yellow Pages; or write Health-Mor, Inc. direct).

\*We will be glad to send you a reprint of this report on request.

### What hospital administrators say about FILTER QUEEN

*"I heartily recommend to any hospital administrator who is presently unhappy with the type of cleaning machine in use, that he try FILTER QUEEN for only two days and the machine will sell itself."*

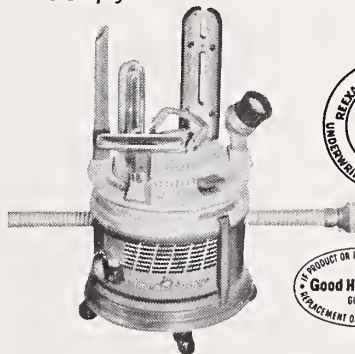
*"The FILTER QUEEN is great—a very important factor in patient areas, and is constructed so as to prevent air turbulence of dust at floor level. Filtering of the air, while in general operation, is also a very important and desirable factor."*

*"One of the most pleasing features of the machine is its quietness. We can even clean in the rooms while occupied by the patients, and many have commented on how pleasant it is not to be disturbed by noisy, old-fashioned vacuum cleaners anymore."*

*"The air exhaust at the top of the unit is a wonderful feature, and the Sanitary Filter Cone is certainly our answer for working in closely confined patient areas."*

*"We thought we had a clean hospital and a fairly good method of achieving acceptable sanitation, but this little machine made us revise our thinking and our methods."*

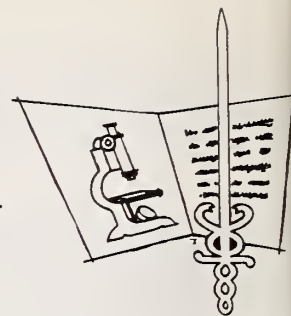
*"A quiet motor which possesses excellent cleaning power and the convenience of having to clean out the cleaning compartment only once a month, has proved very advantageous. One of the most important points . . . is that there is no bag to empty."*



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## ETE—CANCER CURE?

John P. Wilson, M.D., *Atlanta*

**T**HE MOST exciting thing that could be reported on this page would be "CANCER CURE FOUND." The tragedy of advanced and terminal cancer is well known and makes it the most feared disease of all.

The distressing fact is that an estimated 1,200 Georgians, who could be saved, lose their lives each year to cancer. Early diagnosis and proper treatment could save their lives. There will be nearly 9,500 cancer cases in Georgia diagnosed for the first time in 1966. Last year 4,945 Georgians died of cancer—over 40% of these in the 21 to 64 age bracket.

### To Know and Act

This is what the American Cancer Society's Earlier Treatment Education Program (ETE) is about—the Georgians who don't know or act on the facts about cancer. Earlier Treatment Education involves three things—(1) Getting People's Attention, (2) Creating Understanding, and (3) Stimulating Action. This kind of education not only seeks to save lives with today's medical knowledge, but it strengthens and advances the whole fight to conquer cancer. It requires the persistent effort of hundreds of volunteers—one of every four of whom will someday have cancer at the present rate.

Last year Earlier Treatment Education Programs were conducted in 119 Georgia counties. Volunteers—lay and medical—presented educational film/speaker programs 2,344 times to 160,000 persons. Another 45,000 persons saw educational films as part of regular theater programs and millions of leaflets, posters and booklets were distributed through the volunteer programs.

### Six Targets

Six cancer sites are the main "targets" in the ETE Program: colon-rectum, breast, uterus, mouth, skin and respiratory. These sites account for 66% of all cancer in women and 50% of the cancer incidence in men and, in each case, are largely preventable or highly curable when treated early.

The most prevalent cancer common to men and women is colon-rectal cancer causing 500 deaths in Georgia last year. The ETE Program encourages cancer detection examinations—including sigmoidoscopic inspection—annually for all persons over 40.

Breast cancer develops in 1,000 Georgians annually and kills 400. This cancer is 82% curable when treated while still localized. ETE stresses monthly breast self-examination for all women.

Uterine cancer is Georgia's most prevalent form of cancer and although death rates have dropped more than 50% in the last 25 years, 300 still die of this cancer each year. The educational goal is an annual pelvic examination including a "Pap" smear for all women over 20 years of age.

Mouth cancers cause nearly 150 Georgia deaths each year. ETE stresses good dental care, regular examinations and alertness to any sore or irritation that fails to heal.

Skin cancer, being cured in most cases, still causes nearly 100 Georgia deaths a year. Education stresses alertness to changes in skin conditions, sores that fail to heal, and avoiding excessive exposure to sunlight and other radiation.

Lung cancer is Georgia's largest cancer killer—800 deaths annually. Most authorities agree now that as much as 75% of all lung cancer can be prevented by not smoking cigarettes. The program is primarily aimed at school age children to prevent early formation of the smoking habit. Films are also "adult aimed" to encourage stopping.

The "Seven Danger Signals" remain a major weapon in the educational "war against cancer" but today the American Cancer Society's Earlier Treatment Education effort is more and more on an adequate cancer detection examination, before there are symptoms or "danger signals," as the best possible insurance against incurable cancer.

340 Boulevard, N.E.

Approved by the Professional Education Committee, Georgia Division, ACS.



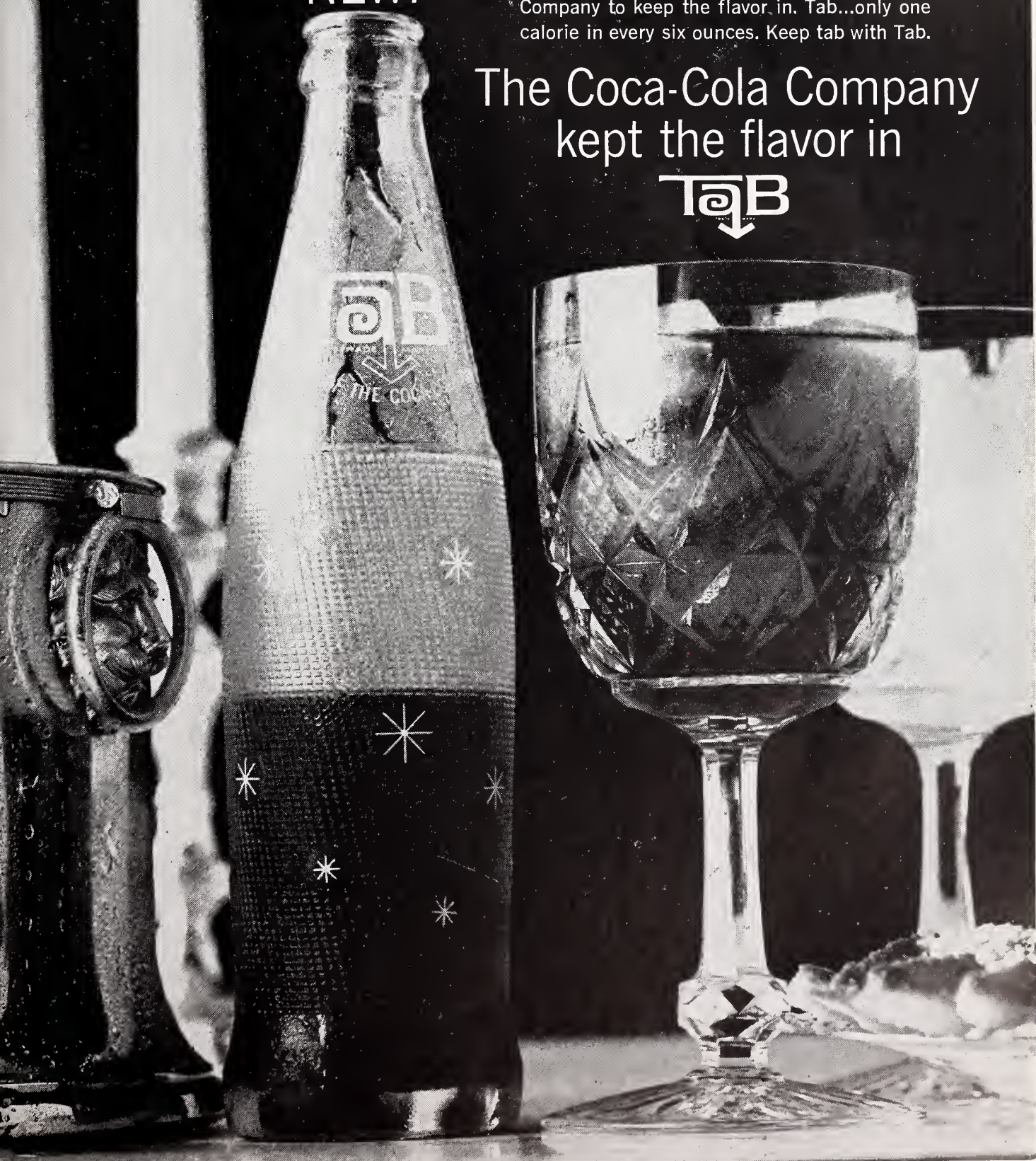
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taste so good?

An elegant evening . . . candlelight, crystal,  
dinner for two. And the elegant complement  
...new one-calorie drink. The difference in Tab  
is flavor. You see, anyone can take the calories  
out of a soft drink. But it took The Coca-Cola  
Company to keep the flavor in. Tab...only one  
calorie in every six ounces. Keep tab with Tab.

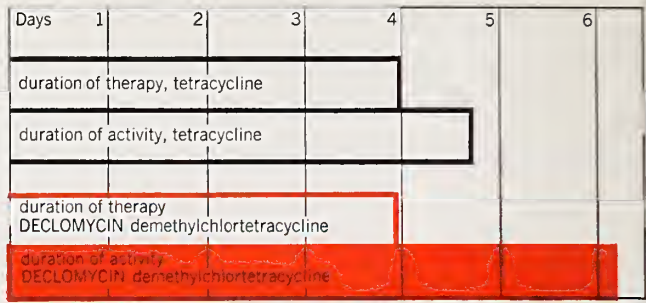
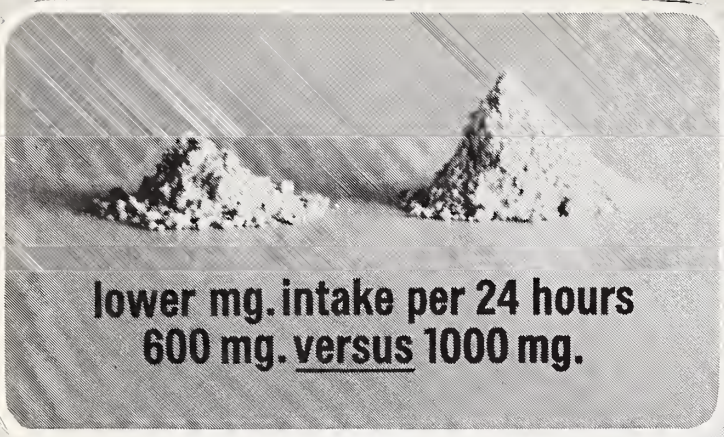
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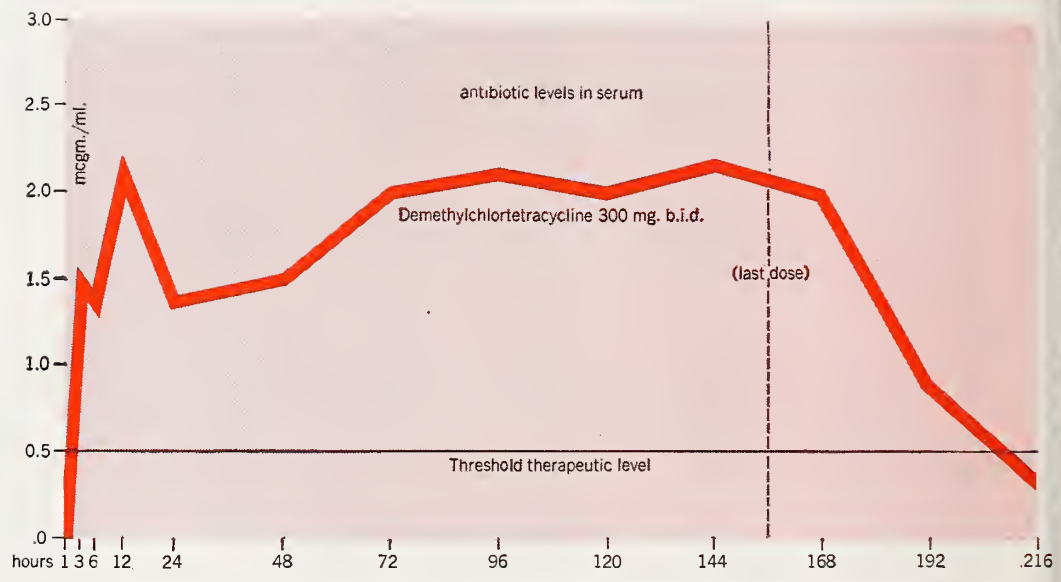




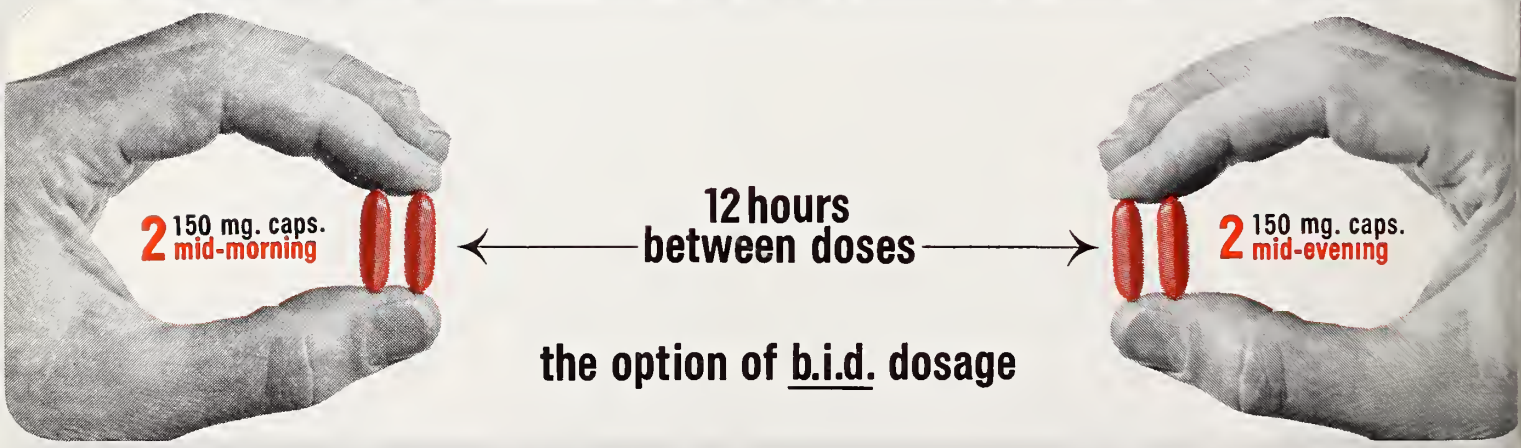


1-2 days "extra" activity

higher  
activity levels  
than other  
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with less  
peak-and-valley  
fluctuation



From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.; Amer. J. Med. Sci. 243:296 (Mar.) 1962



the "extra" benefits raise the  
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# DECLOMYCIN

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150 mg. CAPSULES

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. Side effects typical of tetracyclines include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation) and increased intracranial pressure (in young infants). Also, very rarely, anaphylactoid reaction. Reduce dosage

in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage) patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals. Capsules, 150 mg. and 75 mg. of demethylchlortetracycline HCl. Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d.





## PREVENTION OF STROKE AND CORONARY DISEASE

J. Gordon Barrow, M.D., *Atlanta*

**T**HERE IS little doubt that this country is experiencing a true epidemic of coronary thrombosis. It is the leading cause of death and disability, and as such, it deserves every effort that we can bring to bear to reduce its toll.

Epidemiologic studies have been successful in identifying certain risk factors which are consistently associated with an increased risk of coronary thrombosis. The more important of these are a high saturated fat diet, elevated serum lipids, cigarette smoking, lack of exercise and uncontrolled hypertension. Other factors such as age, sex, family history of premature coronary disease, stress, and diabetes are less subject to modification.

By using the data from these epidemiologic studies it is now possible to determine with great accuracy which persons in the population have an increased risk for developing premature coronary thrombosis. Once these susceptible individuals are identified, can we modify their risk successfully?

### Five-Year Follow-Up

Although it is clear that large populations on low fat diets have low coronary disease rates, there has been some doubt that modification of the diet relatively late in life will have any effect. Recently, however, reports of the five-year follow-up of the participants in the New York and Chicago anti-coronary clubs have confirmed that modification of the diet according to the recommendations of the American Heart Association (a moderately low fat, low cholesterol diet with a high polyunsaturated to saturated fatty acid ratio) will significantly reduce the risk of coronary thrombosis. This diet is not difficult to follow and patient adherence has been good. Copies of

this diet are available from the Heart Association.

One of the most interesting findings is that cigarette smoking increases the risk of coronary thrombosis two or three fold, but that the risk in persons who quit immediately falls to that of persons who have never smoked. This implies that we should advise our high risk patients to stop cigarettes.

Data is accumulating rapidly that an increase in regular exercise will not only reduce the risk in high risk normals but will reduce the risk of future recurrences in individuals who have already experienced an attack. Regularity of the exercise is apparently essential.

### Good Drug Control

Good drug control of the blood pressure is now possible in most patients with hypertension. Undoubtedly this will reduce the risk of coronary disease. Moreover, this is the one risk factor for stroke that has been definitely proved and the mortality and morbidity from stroke in any group of hypertensive patients is reduced significantly by adequate drug control of the blood pressure.

In summary then, we can accurately identify the individuals within the population who are at increased risk of premature coronary thrombosis, and we can successfully modify this risk by diet, stopping cigarette smoking, increasing exercise and controlling hypertension. This latter procedure will also reduce the risk of future stroke. We would be foolish doctors not to make immediate use of such information in our own patients and in ourselves.

*Georgia Baptist Hospital*

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

## "THE MEDICAL UNITS 'PLANNING GUIDE'" AND "THE BUSINESS SIDE OF MEDICAL PRACTICE" AGAIN AVAILABLE TO GEORGIA DOCTORS

For the third consecutive year, the Medical Association of Georgia is offering to the doctors of Georgia the American Medical Association-Sears, Roebuck Foundation, Inc. booklets entitled, "The Business Side of Medical Practice," and "The Medical Units 'Planning Guide.'" The material is free of charge and either or both may be obtained by writing to the *MAG Head-*

*quarters Office, 938 Peachtree St., N.E., Atlanta, Ga. 30309.*

Each booklet, constructed of heavy vellum stock, measures approximately 12" x 9" and contains charts, graphs, illustrations, floor plans, etc. Both are made for easy handling and make a nice addition to a doctor's office library.



# Blood-glucose screening for all your patients?

...because "Abnormalities of glucose metabolism are among the [most common] encountered in clinical practice...."\* Simple, quick, economical blood-glucose screening with DEXTROSTIX® Reagent Strips is practicable in every regular physical examination, emergency situation, and whenever hypo- or hyperglycemia may be of clinical significance—for "The precision and accuracy of DEXTROSTIX ... meet the need for an always available simple screening method...."\* All that is required for screening with DEXTROSTIX is 60 seconds and a globular drop of capillary or venous blood. Abnormal readings will be a valuable aid to diagnosis; normals will help you establish an important baseline for future reference.

\*Marks, V., and Dawson, A.:  
Brit. M. J. 1:293, 1965.

**DEXTROSTIX—**  
provides a clinically useful determination when performed according to directions†

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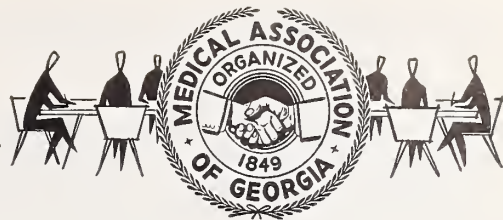
## Yes—all your patients

AMES COMPANY, INC.  
Elkhart, Indiana





# THE ASSOCIATION



## DEATHS

**Maurice Lee B. Clarke**, 64, of Atlanta, died November 8, 1965, in a private hospital.

Dr. Clarke, a native of Atlanta, had practiced medicine in the Atlanta area for more than 20 years. He was on the staff of several hospitals including Crawford W. Long and Jessie Williams.

He was a graduate of the University of Georgia and the Emory University Medical School where he later became an instructor.

Dr. Clarke was a member of the Georgia and American Heart Associations, Fulton County Medical Society, the Medical Association of Georgia and the American Medical Association.

Survivors include his wife, the former Frances Scruggs, and a son, Lee B. Clarke, II, Fernandina Beach, Fla.

**Allen Albert Cole**, Medical Director of Macon Hospital since 1957, died November 2, 1965, in the hospital after an extended illness.

Dr. Cole, 62, was chief of medical services for Warner Robins Air Force Base before his retirement from service in 1945.

A native of Millersburg, Ohio, Dr. Cole was the son of the late Dr. Albert Thomas Cole and the late Mrs. Alice Cary Cole. He was a graduate of Ohio Wesleyan and received his medical degree from Western Reserve University. He had been a resident of Macon for 17 years.

At one time Dr. Cole was director of nurses training at Macon Hospital and was chairman of the Executive Committee of the hospital before becoming director.

Dr. Cole was a member of the Bibb County Medical Society, Vineville Methodist Church and Phi Delta Theta fraternity. His army career started in 1942.

Survivors include his wife, the former Miss Anne Booton; two daughters, Mrs. J. E. Carpenter and Mrs. W. T. Miller, both of Miami, Fla.; one son, Capt. Warner B. Cole, stationed in Baberhausen, Germany; and seven grandchildren.

## COUNTY MEDICAL SOCIETIES

The COBB COUNTY MEDICAL SOCIETY will sponsor a symposium in Marietta, Georgia, Friday afternoon January 28, 1966, beginning at 2:00 P.M. and concluding that evening after dinner. The subject of the symposium will be "The Law—Moral, Medical, Civil—Man's Responsibility." The principal speaker will be Dr. Noel Mailloux, Professor of Psychology, University of Montreal, Canada; Director—Center of Research in Human Relations, Montreal; and President, Fifth International Congress of Criminology; Dr. Mailloux is also a Dominican priest. The symposium will be held in the main downstairs meeting room of the First Baptist Church, Church Street, Marietta, Georgia. Physicians

may make dinner reservations by contacting Dr. Noah D. Meadows, 208 Tower Road, Marietta, Georgia.

Guest speakers for the November 15, 1965, meeting of the DeKALB COUNTY MEDICAL SOCIETY were Rives Chalmers, M.D., Atlanta, and The Reverend Charles V. Gerkin, Decatur. Their topic concerned Medicine and Religion.

GEORGIA MEDICAL SOCIETY, with the cooperation of the First District Heart Association, will sponsor a series of four public health forums concerned with cardio-vascular disease with emphasis on stroke-rehabilitation. Medical Society members and out-of-town experts will participate in the program.

Samuel Poole, M.D. of Gainesville is the new President of the HALL COUNTY MEDICAL SOCIETY. Serving with him in 1966 will be Fred Bloodworth, M.D., Gainesville, Vice-President; and A. D. Wright, Jr., M.D., Gainesville, Secretary. Dr. Poole succeeds Harvey Newman, Jr., M.D., also of Gainesville. Before leaving office, Dr. Newman appointed an advisory committee to work with the Appalachian Medical Planning Council. The committee will work with a larger one from the district medical organizations. Robert Stephenson, M.D., Emory University, was the main speaker for the evening; his topic was peptic ulcers.

Henry Scoggins, M.D., Augusta, was recently elected President of the RICHMOND COUNTY MEDICAL SOCIETY. Daniel Sullivan, M.D. is President-Elect; other officers are Stuart H. Prather, Jr., M.D., Vice-President, and Ronald F. Galloway, M.D., Secretary-Treasurer.

SOUTHWEST GEORGIA MEDICAL SOCIETY held its last bi-monthly meeting in November at Blakely. Newly elected officers are David Weatherby, M.D., Ft. Gaines; Homer P. Wood, M.D., Ft. Gaines, Vice-President; W. B. Reynolds, M.D., Edison, Secretary-Treasurer; and MAG Delegate and Alternate Delegate, respectively, H. L. Lassiter, M.D., and R. E. Jennings, M.D., both of Arlington.

THIRD DISTRICT MEDICAL SOCIETY has elected the following officers for 1966; President, Jack C. Hughston, M.D., Columbus; R. A. Collins, Jr., M.D., President-Elect; and Fred Thompson, M.D., Secretary-Treasurer, both of Americus, and Frank Wilson, M.D., Leslie, District Counselor.

WALKER-CATOOSA-DADE COUNTY MEDICAL SOCIETY has elected the following officers to serve for 1966: President, M. K. Cureton, M.D., Lafayette; President-Elect, George Vassey, M.D.; Secretary-Treasurer, Sarah Goolsby, M.D., Rossville; MAG Delegate, M. K. Cureton, M.D., and Alternate Delegate, Robert T. Jones, M.D., Lafayette.

W. Roy Hancock, M.D. of Jacksonville, Florida, an internist who specializes in diseases of the stomach and in-



## THE ASSOCIATION / Continued

testinal tract, spoke at the November meeting of the **WARE COUNTY MEDICAL SOCIETY**. Dr. Hancock spoke on, "Postoperative Complications of Stomach Surgery." The speaker, a native of Atlanta and a graduate of the Medical College of Georgia, served his internship and residency in Augusta.

## PERSONALS

### First District

**T. A. Peterson**, Savannah, board member of the Georgia Society for Crippled Children and Adults, recently moderated a symposium, entitled "The Influence of Governmental Programs on Voluntary Health Agencies," at the society's state annual meeting in Atlanta.

### Second District

The Fourth Annual Medical Seminar at John D. Archbold Memorial Hospital, Thomasville, was held December 2 and 3, 1965. The program included feature addresses by four of the nation's most prominent physicians and panel discussions approved for American Academy of General Practice credit in Category I. The Georgian appearing on the program was **J. Willis Hurst**, Atlanta, Professor and Chairman of the Department of Medicine, Emory University School of Medicine. His topics included Coronary Artery Disease and Physical Diagnosis of the Heart.

### Third District

**Joe A. Bain**, Commissioner of Public Health for Muscogee County, and **Leslie Williams**, President of the Muscogee County Mental Health Association, were guest speakers at the meeting of the Woman's Auxiliary to the Muscogee County Medical Society held October 20, 1965, at the Woman's Club House, Columbus. The speakers discussed the rehabilitation residence and clinic for alcoholics to be built in Muscogee County in the coming year.

### Fifth District

**Joseph L. Izenstark** has been elected a member of the governing council of the Southeastern Chapter of the Society of Nuclear Medicine. He attended the meeting of the International Congress of Radiologists in Rome, Italy, and presented a paper on medical radiological practice. Dr. Izenstark also toured several European countries and visited hospitals in Rome and London.

**Charles M. Huguley, Jr.**, addressed the Houston Society of Internal Medicine on "Drug-related Blood Dyscrasias" October 28, 1965.

**John T. Mauldin**, Atlanta, discussed public laws No. 89-97 in a recent symposium on the influence of governmental programs on voluntary health agencies, held by the Georgia Society for Crippled Children and Adults at their recent state annual meeting.

**Walter L. Bloom**, Atlanta, was cited for six years of voluntary service as a member of the Board of Directors of the Georgia Society for Crippled Children and

Adults. During his tenure with the organization, Dr. Bloom served as chairman of the Patient Services Committee, and was a member of the Executive Committee.

Dr. and Mrs. **Edgar D. Grady** visited Italy, Austria, and Germany for four weeks in September and October. Dr. Grady participated in a program on experimental radiation at the International Congress of Radiology in Rome. He was one of the few surgeons at the conference, attended by more than 5,000 radiologists.

His paper entitled "Oxygen Saturation of Tumor Cells to Increase the Effect of Internal Radiation" described work that he and **Thomas R. Nolan** performed at the Ferst Research Center, Piedmont Hospital, Atlanta.

After the Conference, Dr. and Mrs. Grady visited the hospital in Innsbruck, Austria, where, in addition to the Max Planck Institute, Mrs. Grady (Dr. Charlotte Kitzinger) worked prior to coming to the United States.

Three Atlanta specialists were featured speakers at the American Academy of Dermatology's 24th Annual Convention held in Chicago, December 4-9, 1965.

**Sidney Olansky**, Emory University, headed a panel on venereal disease; **William J. Brown**, Chief of the U. S. Public Health Service's VD program in Atlanta was a member of the panel; and **Irving G. Kagan**, Chief of the Parasitology Unit of the U. S. Communicable Disease Center in Atlanta, presented a paper at another session on parasitic diseases.

**S. C. Rutland**, Atlanta, has recently retired from the Georgia Department of Public Health after 40 years of service. Upon his retirement, November 1, 1965, he was serving not only as Deputy Director of the Georgia Department of Public Health but also as Director of the Department's Physical Health Division and Acting Director of Epidemiology Division and Special Services Branch.

**William A. Mason**, Chief Public Health Educator, Health Education and Training Service, Georgia Department of Public Health, recently toured Scandinavia for three weeks.

He was a member of a group of 32 Methodist ministers and laymen who made the trip under the sponsorship of the Division of Evangelism of the Methodist church. They left Atlanta on October 31 and began their tour in Stockholm. They visited Sweden, Norway and Denmark and spent approximately one week in each country.

Dr. Mason studied health facilities and conferred with Scandinavian health officials.

**Lester Rumble, Jr.** was a panel participant on the "Problem Solving Clinic" at the Regional Institute on Operating Room Nursing sponsored by the Association of Operating Room Nurses on November 13 at the Dinkler Plaza Motor Hotel, Atlanta. Dr. Rumble has recently been elected to Fellowship in the American College of Chest Physicians.

**John T. Godwin** was recently invited to attend the White House Conference on International Cooperation on November 30. Dr. Godwin participated in the Panel on Health.

**Nanette K. Wenger** lectured to the Georgia Dental



Association in Atlanta, October 12, on "Cardio-vascular Emergencies in Dental Practice."

**J. Willis Hurst, Herbert R. Karp, Robert C. Schlant and E. Alan Paulk** participated in a program of the American Heart Association in Miami, Florida, on October 15-17. Dr. Hurst also participated in the program for the Texas Heart Association meeting in Austin, Texas, on September 18.

**Sam M. Wilkins, Jr.**, was a visiting faculty member at the Erlanger Hospital in Chattanooga, Tennessee, October 18-19 where he gave four talks to house and

attending staff. He also addressed the Chattanooga Surgical Society on the 18th.

#### Sixth District

The nomination of **Claude Pennington** to serve on the Executive Committee of the Macon Hospital Medical Staff was approved recently by the hospital commission.

He will serve a three-year term on the committee.

Dr. Pennington was elected by secret ballot to fill the slot to be vacated by **W. D. Jarrett**, whose term is expiring.

## NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Ball, Wesley J. Active—Georgia Medical Society	458½ W. Broad Street Savannah, Georgia 31401
Crippen, Donald A. Active—Stephens	800 Doyle Street Toccoa, Georgia 30377
Davis, Billy J. Active—Hall	Blairsville, Georgia 30512
Eichel, Berkley S. Active—Fulton	144 Ponce de Leon Avenue, N.E. Atlanta, Georgia 30308
Fishman, Leonard Active—Fulton	1938 Peachtree Street, N.W. Atlanta, Georgia 30309
Glancy, David L. Active—Fulton	478 Peachtree Street, N.E. Atlanta, Georgia 30308
Gutman, F. A. Associate—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303
Jones, Lewis E. Service—Fulton	441 W. Peachtree Street, N.E. Atlanta, Georgia 30308
Moore, Richard W. Active—Georgia Medical Society	905 Montgomery Street Savannah, Georgia 31401
Nickerson, John F. Associate—Fulton	35 Linden Avenue, N.E. Atlanta, Georgia 30308
Oosterhoudt, James J. Active—Whitfield	306 W. Waugh Street Dalton, Georgia 30702
Peszczyński, Mieczyslaw Active—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303
Preston, Edwin N. DE-2—Fulton	300 Boulevard, N.E., Box 359 Atlanta, Georgia 30312
Richardson, Howard D. Active—Fulton	Emory University Clinic Atlanta, Georgia 30322
Rodriguez, Fernando Service—Fulton	Atlanta Army Depot, Dispensary Forest Park, Georgia 30050
Shuler, Robert K. Active—Fulton	3451 Peachtree Road, N.E. Atlanta, Georgia 30326
Smithdeal, Charles D. Active—Fulton	144 Ponce de Leon Avenue, N.E. Atlanta, Georgia 30308
Walker, Henry K. DE 4—Fulton	1579 Emory Road, N.E. Atlanta, Georgia 30306

## C. JOSEPH STETLER ELECTED NEW PRESIDENT OF PHARMACEUTICAL MANUFACTURERS ASSOCIATION

The Board of Directors of the Pharmaceutical Manufacturers Association (PMA) recently elected C. Joseph Stetler of Washington, as President of the association, which represents 140 companies who produce more than 90% of the nation's prescription drugs. The action is effective at once.

#### Smith Elected to Parke-Davis Board

At the same time, the Board accepted the resignation of PMA President Austin Smith, M.D., and the Board of Directors of Parke, Davis & Company in Detroit announced it had elected him to its Vice Chairmanship and to the membership of its Executive Committee, effective January 1, 1966.

Stetler has been Executive Vice President and General Counsel of the PMA since 1963. Dr. Smith was PMA's first full-time President, elected to that position in 1959 following his service as editor and managing publisher of the *Journal of the American Medical Association*.

#### Ohio Native

An Ohio native, Stetler, 48, received his law degree from Catholic University in Washington, D. C. in 1938. He is a member of the bar in Washington and Illinois.

From 1935 to 1951 Stetler served in the U. S. Civil Service Commission, the Social Security Administration, the Veterans Administration and the War Claims Commission. Thereafter, he was General Counsel of the American Medical Association and Director of its Legal and Socio-Economic Division.

#### Capable Leadership

George R. Cain, Chairman of the PMA Board and Chairman and President of Abbott Laboratories, said, "I know I speak for the entire membership in saluting the service performed by Austin Smith in their behalf and in the public interest during the past half-dozen critical years in the development of the U. S. pharmaceutical industry. The years ahead are equally important, and we are fortunate in having the outstanding capabilities of Joe Stetler at hand to assume the leadership of our association."





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mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

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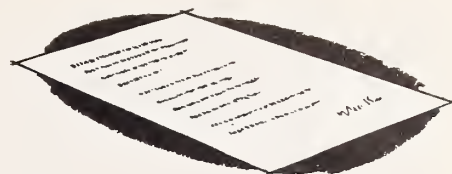
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# ABSTRACTS BY GEORGIA AUTHORS



**Bennett, Robert L., M.D., Warm Springs, Georgia, "Orthotic Devices to Prevent Deformities of the Hand in Rheumatoid Arthritis," *Arthritis & Rheumatism* 8:1006-1018 (Oct)65**

A major factor in the pathogenesis of musculoskeletal deformities in arthritis is persistent faulty positioning of joint structures during rest or activity. In rheumatoid arthritis, two changes may take place in bone and joint to permit kinesiological faults that cause and aggravate structural deformity. First, a loss of the normal resiliency of periarticular tissue, and second, faulty "grooving" of subchondral bone underlying degenerating articular cartilage.

Simple orthotic devices can be made for the fingers and thumb that will permit necessary functional use but prevent most of the persistent position of fault that could lead to structural deformity. Such a device must have certain attributes before the patient will consent to wear it both day and night. First, it must be comfortable and light in weight. Second, it must be acceptable in appearance, stay in place during use, but slip on and off easily when desired. Third, it must be durable and if at all possible have no buckles, straps, clips, buttons, adhesive tape or other holding devices that stretch, break, smell offensively or deteriorate in any way.

Devices to control five common deformities of thumb and fingers are illustrated and discussed.

**Logan, William D., Jr., M.D.; Osler A. Abbott, M.D.; Charles R. Hatcher, Jr., M.D., Emory University Hospital, Atlanta, Georgia 30322, "Acute Tracheal Trauma," *Am. Surgeon* 31:600-602(Sept)65**

Injuries to the trachea are not common, but may institute critical emergencies when they occur. Prompt treatment and management of these injuries are necessary, not only for the critical airway emergency, but also to prevent future stricture. Twenty-three cases of acute tracheal injury treated by the surgical staff of the Emory University School of Medicine are reviewed, with discussion of management.

Knife and gunshot wounds were the most common type of penetrating injuries, and there were eight blunt injuries. Twenty cases were in the cervical area and three in the thoracic trachea. Four patients had complete transection of the trachea.

Seventeen patients had complete recovery. Four had moderately good results and two patients died, one from an associated injury.

**Martin, J. D., Jr., M.D. and George Sutton, M.D., Emory University Hospital, Atlanta, Georgia 30322, "Present Status of Polyps of the Colon," *Am. Surgeon* 31:551-558 (Sept)65**

The recent appraisal of the relationship of adenomas of the colon to car-

cinoma raises many unanswered questions. There is a need for a logical and functional standardization of nomenclature as well as the basic knowledge of each. The recent literature on juvenile and Peutz-Jeghers polyps has been reviewed and their benign nature has been discussed.

Current concepts of villous adenomas and familial polyposis indicate their tendency to malignant change. The debate about the malignant potential of adenomatous polyps has been described.

The evidence concerning the malignant potential is difficult to evaluate, for every statement seems to be contradicted. The rate of growth is one of the most valuable guides to the degree of malignancy. Cost of observation, concern of the patient and possibility of hemorrhage make treatment necessary. There is agreement with Woodward's assumption that any patient with blood in the stools, increased mucus, change of bowel habit or uneasy feeling in the abdomen may have a premalignant or a malignant lesion until examinations have determined that malignancy does not exist. This can only be done with assurance by the pathologist who has the complete lesion for careful examination.

**Gerle, Richard D., M.D.; Lewis A. Walker, M.D.; James L. Achord, M.D., and H. Stephen Weens, M.D., 80 Butler Street, S.E., Atlanta, Georgia 30303, "Osseous Changes in Chronic Pancreatitis," *Radiol.* 85:330-337 (August)65**

Sporadic cases of intramedullary fat necrosis with associated bone destruction in persons with acute, sub-acute, and traumatic pancreatitis as well as pancreatic carcinoma have been reported. Few have pointed out the accompanying roentgenographic manifestations. The authors have collected a series of cases with radiographic bone changes considered to be the result of intramedullary fat necrosis in patients with chronic pancreatitis.

The pathogenesis of these osseous changes is not fully understood. Alcohol and its close relationship to fat metabolism has been considered a possible cause. However, osseous changes have been observed in patients with non-alcoholic pancreatitis. The most likely explanations for the osseous manifestations seen in chronic pancreatitis appear to be:

1. Calcification or ossification in a previous area of acute intramedullary fat necrosis.
2. Bone infarction as the result of specific vascular effects from fat necrosis.

Roentgenologic changes in both acute pancreatitis and chronic pancreatitis have been observed and show a markedly different appearance. In the former, extensive intramedullary trabecular bone destruction is noted and may be reversible. In chronic pan-

creatitis the changes are best classified as either "metadiaphyseal," or "epiphyseal" in type. The "metadiaphyseal" type reveals a moderately well circumscribed area of calcification and/or ossification in the intramedullary canal of one or more long bones. The "epiphyseal" type is mainly in the subchondral region, and early cases demonstrate a band of rarefaction in the subcortical zone. The later stages show definite increased density plus smudging of the trabecular pattern. This appearance cannot be differentiated from the other forms of aseptic necrosis.

**Powell, R. W., M.D.; B. L. Redd, M.D.; and S. A. Wilkins, Jr., M.D., Emory University Clinic, Atlanta, Georgia 30322, "An Evaluation of Treatment of Cancer of the Larynx," *Am. J. Surg.* 110:635-643(Oct)65**

A retrospective review of the charts of 175 patients with malignant disease of the larynx seen over a 23 year period was carried out by a surgeon and radiotherapist simultaneously. Both agreed upon the staging according to the TNM method as reported by the American Joint Committee for Staging. In Stage I larynx cancer, irradiation or surgery is equally effective in disease control. In Stage II glottic cancer, surgery is more effective than irradiation as the initial treatment method. Subsequent surgery however, can control about half the x-ray treatment failures. In Stage II cord cancer, the site of recurrence or metastasis seems significantly different depending upon the primary treatment method. Surgery is probably the treatment of choice in supraglottic larynx cancer. In the irradiated group of patients who required subsequent surgery, complications were not significantly increased. During the interval of this study, 40 patients died of and with laryngeal cancer while 16 died of other causes. Eight of these 16 died of primary lung cancer.

**Peirce, E. Converse, II, M.D. and Perry Sprawls, Jr., M.S., 454 Woodruff Memorial Building, Emory University, Atlanta, Georgia 30322, "Ventricular Fibrillation," *Arch. Surg.* 91:516-520(Sept)65**

The relative effectiveness of potassium citrate injected into the ascending aorta, 60-cycle alternating current (AC) shock, and condenser discharge (DC) shock in affecting reversion from ventricular fibrillation were compared at 37°C (98.6°F) and 25°C (77°F). Studies were made open-chest in perfused dogs to permit randomization of defibrillation methods. This was possible since the heart was well supported whether a defibrillation attempt was effective or not. The AC shocks were of much lower power and consequently longer duration than the DC shocks. The following conclusions were drawn:

1. At normal temperature potassium citrate injections and DC shock



- were equally effective while AC shock was less effective.
2. In hypothermia (25°C) there was improvement in the effectiveness of both potassium citrate and AC shock. AC and DC shock were equally effective while potassium citrate was the most effective method.

The paper discusses the need for a more fundamental evaluation of AC and DC shock effectiveness and suggests that the particular modality of DC shock chosen was more effective than the AC shock not because it was DC shock but because it was of a higher power.

**McDonald, Robert L., M.D. and Cecil F. Lanford, M.D., Emory University School of Medicine, Atlanta, Georgia, "Effects of Smoking on Selected Clinical Obstetrical Factors,"** *Obst. & Gynec.* 26:470-475(Oct)65

To assess the effects of smoking on various clinical factors, on the incidence of a variety of obstetric complications, and the sex of the offspring, 177 single white primigravidas were classified by smoking habits as non-, light, and, heavy smokers. Following delivery, each case was categorized, by virtue of clinical criteria, as "normal" or "abnormal," and each abnormal case subclassified by type of complication. No significant mean age or educational differences were found for maternal weight gain, maternal pre-pregnancy weights, labor times, or mean birth weights.

The major findings were related to increased incidence of prematurity, preeclampsia, and premature rupture of the membranes among heavy smokers. Heavy smoking was found to decrease the incidence of female births as well as to reduce reliably mean female birth weights.

**Harris, Thomas R., M.D. and Robert L. Rainey, M.D., Medical College of Georgia, Augusta, Georgia, "Ideal Isolated Levocardia,"** *Am. Heart J.* 70:440-448(Oct)65

Levocardia with situs inversus, a rare congenital disorder, is usually associated with severe cyanotic congenital heart disease. Review of the literature reveals reports of over 160 cases, of which only nine presumably had normal hearts. The case presentation here recorded concerns an individual in whom cardiac catheterization, cineangiography, and radiological studies of the abdominal viscera demonstrated a hemodynamically normal, left-sided heart associated with partial situs inversus viscerum. Normal spatial arrangements of the heart chambers and the great vessels were also verified in what is thought to represent an example of ideal isolated levocardia.

**Wenger, Julius, M.D.; G. W. Gingrich, M.D.; and Joseph Medeloff, M.D., 4158 Peachtree Road, N.E., Atlanta, Georgia, "Sclerosing Cholangitis—a Manifestation of Systemic Disease,"** *Arch. Int. Med.* 116:509(Oct)65

In a unique case of obstructive jaundice, exophthalmos, and lymph node enlargement, sclerosing cholangitis and inflammatory pseudotumor of the orbit were found. The pathologic changes in the tissue obtained from the bile ducts and the orbit were identical histologically. The lymph node enlargement

was limited to regional nodes draining the common duct and the orbit and revealed a pattern of reactive follicular hyperplasia. An increase in serum  $\gamma$ -globulin was noted early in the illness and has persisted. Continued corticosteroid therapy has been required for the control of symptoms during a four-year period of observation. Certain features of this case, and others which have been reported, suggest that this disease of connective tissue may affect the orbit, thyroid, mediastinum, retroperitoneum, or the hilum of the liver in an unpredictable manner.

**Goodwin, Burton D., M.D. and Brit B. Gay, Jr., M.D., Emory University Clinic, Atlanta, Georgia 30322, "The Roentgen Diagnosis of Teratoma of the Thyroid Region,"** *Am. J. Roentgenol.* 95:25-31(Sept)65

The presence of a cervical mass in an infant or young child should lead the clinician and roentgenologist to suspect the entity of teratoma of the thyroid region. In addition to briefly presenting two new cases, the available English literature was reviewed, tabulating the roentgen findings of those reported cases in which film interpretations were available. Demonstration of calcification within the tumor, when present, is virtually diagnostic of cervical teratoma, having been identified in about 40% of the cases. Distortion of the tracheal air column on the roentgenogram is an even more frequent sign but is much less specific. The roentgen differential diagnosis is presented.

In a general discussion of cervical teratomas, the occurrence, nomenclature, pathologic findings, clinical features, treatment, and prognosis are reviewed. The importance of accurate and early diagnosis is stressed, since failure to surgically remove the teratoma leads to progressive respiratory embarrassment and death.

**Anthony, James E., Jr., M.D., Dekalb General Hospital, Decatur, Georgia, "Use of Marlex Mesh in the Repair of Muscle Hernias of the Leg,"** *Am. Surgeon* 31:570-571(Sept)65

Fascial defects over the anterior tibial muscles are rather frequent. Most of these require no treatment but if the defect is large or multiple simple suturing may not be sufficient. A 38-year-old man was reported in whom multiple muscle hernias were present in both legs for several years. In one leg several small defects were sutured easily resulting in excellent relief of discomfort. In the other leg the defects were greater and more widely separated. For this reason Marlex Mesh, a plastic polyethylene fiber, impervious to water, was used as an on-leg graft. Wound healing was excellent without evidence of a subcutaneous foreign body and the patient has performed his job as a security guard without pain for the first time in years.

**Sato, Tsuneharu, M.D.; Virendra B. Mahesh, M.D.; and Robert B. Greenblatt, M.D., Medical College of Georgia, Augusta, Georgia, "Effect of Clomiphene Citrate (MRL 41) on Thyroid Function in Female Rats,"** *Endocrinology* 77:491-495(Sept)65

The effects of clomiphene citrate treatment (7-16 days) on the thyroidal

<sup>131</sup>I uptake and the serum resin sponge uptake of radioactive triiodothyronine (T<sub>3</sub>) were compared with those of estradiol benzoate treatment in, intact, spayed, and spayed hypophysectomized adult female rats. Serum resin sponge T<sub>3</sub> uptake was lowered in all the groups. No changes were observed in thyroid weight. Thyroidal <sup>131</sup>I uptake was increased only in castrated rats. The effect of estrogens and clomiphene, when administered simultaneously, appeared to be additive in the lowering of serum resin sponge T<sub>3</sub> uptake. These observations suggest that even though clomiphene may behave like an anti-estrogen in its effect on the uterus, under the same conditions its effect on thyroid function resembles those of an estrogen.

**Lyon, James B., M.D.; Salim Haijar, M.D.; and John D. Thompson, M.D., 2558 Tanglewood Road, Decatur, Georgia, "Vaginal Hysterectomy and Partial Vaginectomy for Carcinoma in situ of the Uterine Cervix,"** *South. M. J.* 58:937-944(August)65

Reported cases of carcinoma in situ of the vagina following hysterectomy for carcinoma in situ of the cervix are becoming more numerous. These can be explained by the multicentric theory of the origin of cancer, which indicates that the removal of an adequate vaginal cuff is a most important part of any operative therapy for carcinoma in situ of the cervix. In addition to other advantages of vaginal hysterectomy, an adequate vaginal cuff can be removed easily with this approach, and its technique is described.

All cases must be proved by cone, and Schillers stain is applied to the cervix and vagina before both cone and the hysterectomy, which is done six weeks later, so that all positive areas can be removed for histologic study. Conization is not adequate treatment for carcinoma in situ, and these patients are given definitive treatment unless good reason exists to do otherwise.

The clinical results of the first 100 patients so treated are reported.

**Roach, George S., M.D. and Marton Majors, M.D., 144 Ponce de Leon Avenue, N.E., Atlanta, Georgia 30308, "Removal of a Toy Bullet from the Lung with a New Instrument,"** *Arch. Otolaryng.* 82:403-404(Oct)65

This article describes a new corkscrew-type instrument devised and used for removal of a plastic bullet which was presenting in the bronchus with the cone-shaped end up. All available instruments had been tried to no avail in that they would not grasp the bullet with sufficient traction for removal or dislodgement.

The instrument was made of a steel rod 47 cm. long and 2 mm. in diameter. Its end was sharp and pointed, continuing into a corkscrew of 13 mm. The other end of the rod had a vertical handle. To protect the walls of the bronchial tree, a protective sheath was devised, 41 cm. long and 2 mm. in diameter. This also was made of stainless steel. To insure that the instrument would pass the end of the protective sheath by only the desired length, a stopper was put on the rod which was adjustable to the desired length.



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# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

### $\beta$ -Hemolytic Streptococci<sup>2,3,1</sup>

2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

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## SUMMARY OF RECENT MAG COUNCIL AND EXECUTIVE COMMITTEE ACTIONS

(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal.)

### Executive Committee of Council/October 24, 1965

**1966 MAG Conference on Medical Education**—Dr. Thomas Goodwin, Chairman of the MAG Medical Education Committee, suggested that the 1966 MAG Conference on Medical Education be deferred for another year. Dr. McDaniel suggested that the Association consider a meeting of the leadership of MAG with leadership from Emory University School of Medicine, Medical College of Georgia, Georgia State Health Department, etc., to review available government programs in the field of health care. By general agreement, it was recommended that President Alexander meet with Drs. Cowart, Goodwin, Godwin and Venable to devise and plan such a meeting, and that Dr. Martin of the State Board of Health also be asked to participate. This type meeting was then approved and recommended by Executive Committee and they suggested that the proposed Medical Education Conference be deferred in favor of this other type meeting.

**Proposed Augusta Pediatric Center**—At the September 25-26, MAG Council meeting, a presentation was made concerning a proposed Pediatric Center for Augusta, Georgia. The Council, at that time, voted to defer action on the matter until such time as the Richmond County Medical Society and the Georgia Pediatric Society could approve such proposal. Dr. Addison Simpson presented a resolution from the Richmond County Medical Society approving this proposed facility which also was adopted by the private practicing pediatricians in Augusta. After general discussion, on motion duly made and seconded, the Executive Committee of MAG Council voted to indorse in principle the resolution presented by the Richmond County Medical Society.

**Medical College of Georgia Circuit Courses**—President Alexander presented the program of the Medical College of Georgia Postgraduate Education "Circuit Courses" now in operation under the co-sponsorship of the Medical College of Georgia, GAGP and MAG. By general agreement, it was recommended that a letter of commendation from President Alexander be sent to Dr. Harry O'Rear, President of the Medical College of Georgia, expressing the appreciation of the Association for this excellent program of postgraduate medical education for the profession.

**Washington, D. C. Welfare Department "Medicare" Meeting Report**—MAG Secretary, John Mauldin, reported on a three day meeting in Washington, D. C., with members of the State Department of Family and Children Services, as sponsored by HEW. This report was received for information.

**State Health Department Activity on P.L. 89-97**—President Alexander read a letter of October 20, from John H. Venable, M.D., Director of the State Department of Public Health, concerning the implementation of Title 18, P.L. 89-97. By general agreement, it was voted that the entire Executive Committee of MAG Council would act as an "advisory committee" to the Board of Health and Department of Public Health on matters concerning the implementation of those aspects of P.L. 89-97 administered by the State Department of Public Health. It was suggested that the communications from Dr. Venable, as Director of the Department of Public Health, be sent to the MAG President at the Association Headquarters Office for duplication and forwarding to all members of Executive Committee of Council.

**MAG Involvement in P.L. 89-97**—Members of the Executive Committee discussed the possibility of the Association acting as "Carrier" under the provisions of P.L. 89-97, Title 18, Part B. On motion (Eldridge-Brown) it was voted that if the Medical Association of Georgia is eligible to act in the capacity of "carrier," that every effort be made by the Association to function as "carrier" for Title 18, Part B, of P.L. 89-97 as it pertains to Georgia.

**MAG Liaison With State Board of Health**—After discussion by general agreement, it was recommended that the Association invite the Chairman of the State Board of Health or his M.D. designee on the Board to attend all MAG Council meetings. It was also voted to schedule as an agenda item at all MAG Council meetings a report on activities of the Board of Health to be rendered by the Chairman of the Board of Health. It was also recommended that the MAG

President or his designee attend those meetings of the State Board of Health to which MAG may be invited to attend.

**Appointment of Ad Hoc Committee on Hospital Utilization Review Guidelines**—President Alexander discussed appointments of MAG members to an Ad Hoc Committee on Hospital Utilization Review Committees. He stated that such an MAG ad hoc committee would be charged with setting up guidelines for use by hospital medical staffs on this matter. By general agreement, the following MAG members were appointed to this Utilization Review Committee: Harry Hill, Atlanta; John Kirk Train, Savannah; Ernest Proctor, Newnan; Don Schmidt, Cedartown; Charles Adair, Washington; Ben Galloway, Brunswick; and John Mauldin, Atlanta, Ex-officio. Alternates appointed included: Gordon Barrow, Atlanta; Abe Conger, Columbus; E. A. Rosen, Dalton; J. M. Byne, Waynesboro; and Henry C. Jackson, Manchester. It was suggested that Dr. Mauldin call the first meeting of this committee and that the committee elect a permanent chairman at that time for ensuing committee activity.

**Headquarters Office Report**—Mr. Krueger brought up the following items for consideration of the Executive Committee:

(1) By general agreement, it was voted to seek the services of another state medical association Executive Secretary as an administrative consultant to the MAG Headquarters Office Staff for the purpose of surveying certain practices and procedures of the Headquarters Office. Funds for this consultation were to be charged to MAG Headquarters Office travel.

(2) The re-scheduled AMA meeting on medical ethics is to be held March 5-6, 1966, in Chicago, and the five persons designated to attend this meeting in behalf of MAG are as follows: Peter Hydrick, College Park; Thomas Goodwin, Augusta; Robert Wells, Atlanta; George Alexander, Forsyth; and Mr. M. D. Krueger, Atlanta.

(3) Dr. Alexander stated that he had appointed the following MAG members to the Ad Hoc Committee on Guidelines for Crippled Children as requested by Dr. Lackey: L. E. Dickey, Jr., Macon, Chairman; Martin Smith, Gainesville; Robert Mabon, Atlanta; Thomas Ross, Macon; J. T. King, Thomasville; Edwin C. Pound, Jr., Atlanta; David Williams, Augusta; and H. Harlan Stone, Atlanta.

**Treasurer's Report**—Dr. John Atwater, MAG Treasurer, reported on income and expenditures to date, and this report was approved and received for information.

### OTHER BUSINESS—

(1) Executive Committee received recommendations for the 8th District Board of Health appointment as follows: Dr. Van B. Bennett, Valdosta; Dr. W. W. Payne, Brunswick; and Dr. William A. Dickson, Nashville.

(2) Dr. Simpson discussed a forthcoming meeting of operation "Head Start" and stated that an MAG representative ought to attend a forthcoming conference on this project. Mr. Krueger was instructed to contact Dr. Holman of the Medical College of Georgia for further information and Dr. Mauldin was asked to name a representative who could attend such meeting.

### Executive Committee of Council/November 21, 1965

**Voted**—To recommend to Council approval of the budget for 1966 as presented.

**Specialty Society Charges for Secretarial Services**—Dr. Eldridge reported that the specialty societies had been written to ask their opinion of charges for secretarial services rendered by MAG staff. He has had four replies, all affirmative. The Executive Committee then approved the charging for secretarial services to the specialty societies to begin January 1, 1966.

**Steiner Clinic Enlargement**—Dr. Lester Rumble reported that enlargement of the Steiner Clinic of St. Joseph's Infirmary had been requested through the Department of Health, Education and Welfare in order to provide a wider range of services on a statewide level for the treatment of patients with chronic obstructive pulmonary disease. He stated that because this would be a project grant, letters of endorsement were necessary, and he presented copies of such



letters from Fulton and DeKalb County Medical Societies. He requested one from MAG. After discussion, it was recommended that he present this matter to the members of Council at the December meeting.

#### Executive Committee Meeting/November 21, 1965

*Administrative Agency Title XVIII, Part B, P.L. 89-97—*  
(a) Dr. Alexander stated that the Blue Shield Plan of Columbus has offered its services as administrative agency under Part B of P.L. 89-97 but would take no action at the present time.

*"Prevailing Fee Program" Meeting in Macon, December 9, 1965:* The Columbus Blue Shield Plan is sponsoring a meeting in Macon, December 9, to discuss the "Prevailing Fee Program" and asked that representatives of MAG attend. Dr. Henry Jennings, Dr. John T. Mauldin and Mr. Milton Krueger were appointed as MAG representatives. Dr. Jennings plans to invite the Insurance and Economics Board members as well as the Fee Negotiating Committee.

(b) *Progress Report on MAG Efforts as Carrier under Title XVIII, Part B, P.L. 89-97:* Dr. Mauldin gave Executive Committee information on the progress made by MAG to be appointed carrier. He mentioned that Dr. Gordon Barrow had been appointed by Dr. Venable, Director, State Department of Public Health, to represent that department for Hospital Utilization Review and that he would like to ask Dr. Barrow to work with the committee appointed by MAG. The Executive Committee agreed to this suggestion.

*Headquarters Office Report—*In Mr. Krueger's absence, Mr. Moffett reported on the following items:

(a) *AMA Medicare Title XIX Orientation Conference, Chicago, January 20-21, 1966:* Dr. Mauldin and Mr. Krueger were asked to attend as well as Dr. Alexander, Dr. Jennings and Dr. McCain, if possible. The AMA will pay for two representatives who would be Dr. Mauldin and Mr. Krueger.

(b) *State Association Consultant Visit in February 1966:* Mr. Don Taylor, Executive Director, Iowa State Medical Association, has agreed to visit MAG in February 1966.

(c) *Georgia Chapter, American Physical Therapy Association Request:* The Physical Therapy Association has requested that a list of the registered qualified physical therapists be made available to physicians in Georgia. After discussion it was voted to inform the Physical Therapy Association that if a list is supplied to MAG Headquarters the information can be furnished upon request.

#### NEW BUSINESS—

(a) *MAG Scientific Exhibit at Atlanta Graduate Medical Assembly:* It was voted to refer this item to the MAG Public Service Board for future consideration, and to so inform the Chairman of the Atlanta Graduate Medical Assembly.

(b) *Unified Personal Health and Record Form:* This item was received for information.

(c) *Georgia Psychiatric Association Policy:* This policy statement, which affirms approval and support of the objectives and goals of the Division of Mental Health of the State Department of Public Health, was reviewed and referred to the MAG Mental Health Subcommittee.

(d) *Commendations:* Dr. Alexander, with approval of the Executive Committee, will present to the members of Council in December, commendation recommendations for the Editor of *JMAG*, the Woman's Auxiliary, and the MAG Rural Health Committee.

(e) *White House Conference on Health:* Dr. Alexander reported on his attendance at this conference.

(f) *Invitation to Mrs. Schaefer:* It was suggested that Mrs. Bruce Schaefer, Director, Department of Family and Children Services, be invited to the January Executive Committee meeting to discuss legislation with regard to the implementation of P.L. 89-97.

## 1966 PARAMEDICAL PERSONNEL SYMPOSIA TO BE HELD SIMULTANEOUSLY APRIL 12, IN TEN GEORGIA CITIES

Hundreds of Georgia nurses, technologists, and dietitians are expected to attend the 1966 Paramedical Personnel Symposia to be held simultaneously in ten Georgia cities, April 12, 1966.

The Symposia are co-sponsored by the Georgia Heart Association, Georgia State League for Nursing, Georgia Society of Medical Technologists, Georgia Dietetic Association, and the Georgia State Nurses Association. Response to the first Symposia in 1965 was overwhelming; attendance was twice as high as anticipated. A survey made after the Symposia indicated that a real need exists in Georgia for this type of training.

The Symposia this year will be held in the same cities as in 1965: Albany, Atlanta, Augusta, Columbus, Dublin, Gainesville, Macon, Rome, Savannah, Waycross.

The theme of this year's Symposia is "The Medical Team in the Care of the Patient With Myocardial Infarction," and will include a film presentation and short talks by a registered nurse, a medical technologist, and a professional dietitian during a two-hour period.

Sites in each of the ten cities have not yet been chosen, but this decision and other final details are expected to be completed shortly.

## MEDICAL ASSOCIATION MEMBERS ATTEND WHITE HOUSE CONFERENCE ON HEALTH

The White House Conference on Health was held November 3 and 4, 1965, at Washington, D. C. The purpose of the conference, as stated by President Johnson was as follows:

"To bring together the best minds and the boldest ideas to deal with the pressing health needs of the nation. Many citizens have been left behind in the advance toward better treatment and better health—some because of inadequate health manpower; others because of obsolete or scarce treatment facilities; and others because health services are not organized effi-

ciently enough to provide first-rate service. If this nation is to launch a new era for medicine—an era even more dramatic than the last two decades—we must begin by setting new goals. Ours is a great opportunity to advance ideas which will contribute not only to a healthier America, but to a better world. We have the resources; we need only the will and the leadership."

Approximately 900 participants attended, of which about one-half were physicians. There were 12 participants from Georgia.

The format and content of the discussions were



## WHITE HOUSE CONFERENCE / Continued

similar to those of the National Health Forums of 1965, sponsored by the National Commission on Community Health Services. The White House Conference was divided into two general sessions, two luncheon sessions, a summary session, and 18 panel sessions.

It should be mentioned that the present administration is concerned not only with the national health, but also with international health problems. On November 30, 1965, a White House Conference on International

Cooperation was held which included a discussion of health.

It is urged that physicians become more knowledgeable about community health in order that whatever plans are to be made can have the direction of physicians, and that planning can be done in a manner consistent with the highest ideals of the Medical Profession. Unless physicians enter into the planning for future medical care, other individuals will take the initiative and plan for the physicians.

*John Godwin, M.D.*

## NATIONAL CHILDREN'S DENTAL HEALTH WEEK SLATED FOR FEBRUARY 6-12

"Keep a smile for your future" is the slogan for the 18th National Children's Dental Health Week sponsored February 6-12, 1966, by the local dental society and the American Dental Association. The chief objective of this observance is the prevention of dental disease in children through education.

It would be helpful for the public to know some of the dental needs of children and what parents and communities can do to provide the necessary treatment.

1. All children should begin routine dental care at approximately age three. (Many children need treatment prior to this due to decay, traumatic accidents and congenital defects.)
2. A thorough dental examination on any age patient should include diagnostic dental x-rays.
3. Maintain a good home-care program which includes proper tooth brushing immediately after meals.
4. Dental caries, according to the best accredited

research today, is accelerated by the intake of sweets. Therefore, control the amounts of sugar and starches the child takes in, especially between meals. Substitute detergent foods such as fresh fruits and vegetables.

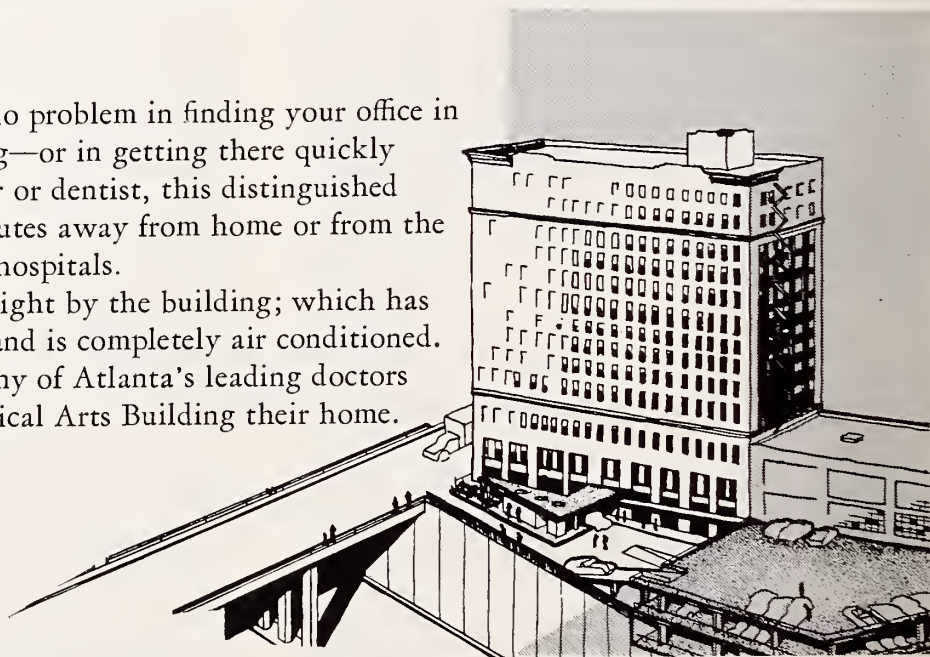
5. Be informed as to the benefit of fluoride in the water supply and also the advantages of topical fluoride applications given in dental offices. Dental research has proved that fluoridation of the communal water supply may reduce decay as much as 65% in a given population, and it may be instituted for as little as \$.09 per person, per year. Topical fluoride although not as effective as communal fluoridation, has reduced decay by 40% in large groups of children.
6. Take your child to the dentist for regular checkups. Most children should visit their dentist every six months but some may have to be treated more often.

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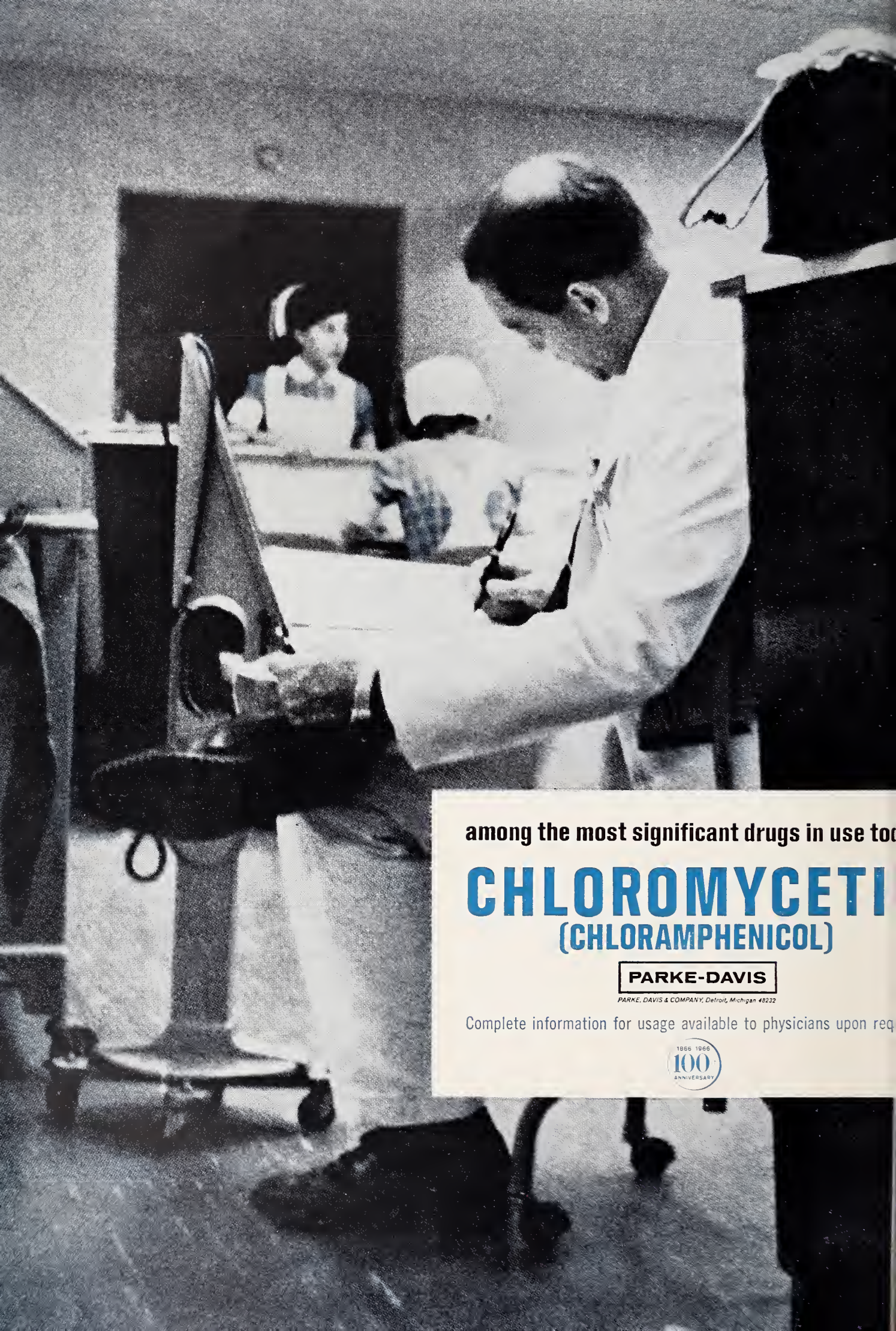
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# NATURAL HISTORY OF THE MEDICALLY HEALED GASTRIC ULCER

Frank P. Rossiter\*

Victor A. Moore, M.D., *Augusta*

- Given proper diagnostic study, medical treatment and follow-up study, the authors feel that the fear of malignancy need not be a serious consideration.

CONSIDERABLE controversy continues to exist regarding proper management of the acute uncomplicated gastric ulcer. Differences of opinion, especially between internists and surgeons, range from casual out-patient management to routine gastric resection. Justification for the latter course has been variously stated to be the likelihood of malignancy, the poor response to medical therapy, and the frequency of recurrence following healing.

## Differentiating Benign From Malignant

In recent years, the response of gastric ulceration to intensive hospital medical management has proved to be a reliable means of differentiating the benign from the malignant ulcer, assuming that strict criteria are met: there must be nothing on x-ray (or endoscopic and cytologic examinations when available) which is inconsistent with benignancy, the patient must not be achlorhydric, and after three weeks of intensive hospital management symptoms, bleeding and x-ray evidence of ulcer must have disappeared. In the study by Smith, Jordan and Boles<sup>1</sup> the incidence of malignancy in gastric ulcers so managed was less than 5%, and less than the surgical mortality for gastric resection. Paustain, Bockus, et al<sup>2</sup> utilizing such a program, but with "satisfactory healing by x-ray" rather than complete ulcer disappearance as a criterion, noted 6.6% of 152 provisionally benign gastric ulcers to be malignant, but this figure fell to 2.6% where cases representing patient and

physician errors were eliminated. Indeed Bachrach's findings<sup>3</sup> suggest that *given comparable follow-up films* ulcerated malignancy virtually never completely disappears on x-ray. If surgical removal is restricted to those ulcers which *fail* to heal on such comparable studies, non-responsive benign ulcers will be removed as well as neoplastic ones but the likelihood of missing ulcerated carcinoma becomes virtually nil.

As regards the likelihood of healing under medical management, the follow-up study of Larsen, et al<sup>4</sup> of the Mayo Clinic reported complete and lasting healing in only 26.8% of 391 gastric ulcer patients treated medically. However, it should be noted that medical supervision of these patients, after diagnosis of ulcer, was carried out in various parts of the country and not under the supervision of the authors. Radiographic evidence of healing was not obtained, but disappearance of symptoms was taken to indicate healing. While such loss of symptoms is an indication of *response* to treatment, experience with both gastric and duodenal ulcers clearly indicates that it cannot be equated with complete healing. Diserens, et al<sup>5</sup> on the other hand, found that in patients treated with intensive hospital management "complete and continued healing of the ulcer was seen in 57%" as judged by follow-up x-ray examinations. The medical mortality was 3.4% as compared to a surgical mortality of 5%. The duration of follow-up period, however, is not stated. In the study by Paustian, et al<sup>2</sup> 61.8% of 152 patients placed on intensive therapeutic trial progressed to complete roentgen-

\* Medical student trainee, Vocational Rehabilitation Summer Traineeship Program.



Healed Gastric Ulcer / Rossiter & Moore

ographic healing. Smith, Boles and Jordan<sup>1</sup> found that 72% of 422 patients treated medically demonstrated radiographic healing.

The decision then, as to whether the simple acute gastric ulcer is best managed operatively or medically should be based not on the malignant potential of the gastric ulcer, nor solely upon its potential for healing, but should consider the expected behavior of gastric ulcer following proved healing. The present study was undertaken to further determine the natural history of the medically treated gastric ulcer once objective criteria for complete healing have been met.

Methods and Materials

Criteria established prior to this study required that the presence and later healing of the gastric ulcer be established by radiological films. Only medically treated gastric ulcers are included in this study, and any surgical intervention such as vagotomy, pyloroplasty, or gastric resection, following medical management but prior to healing, excluded a case from consideration. Simple closure of a perforated ulcer would not have excluded a case from this study but did not occur in the series.

All medical records of patients carrying a diagnosis of gastric ulcer at the Eugene Talmadge Memorial Hospital and all those from the University Hospital of Augusta, Georgia, since 1952\* were reviewed. Eighty-five patients met the established criteria of the study. Results of follow-up x-ray examinations as well as other follow-up data were obtained from subsequent hospital and clinic records, letters to the patients and to their physicians, and by personal contact with the patients or their physician. The majority of follow-up information on private patients was extracted from the records of their physicians. Information sought consisted of results of subsequent barium studies, recurrence of symptoms, occurrence of complications (specifically perforation, obstruction, hemorrhage and weight loss) or gastric surgery, evidence of gastric malignancy, cause of death in patients deceased, and the degree of vocational rehabilitation ultimately obtained in medically healed patients. Each patient was also studied from the following viewpoints to determine what if any effect various factors might have on subsequent ulcer behavior: age, sex, duration of ulcer, co-existence of duodenal ulcer, size and location of ulcer crater, concurrent diseases and concurrent adrenal steroid therapy. No attempt was made to assess the percentage of patients responding to medical management in this study since the medical programs were varied

and information as to the exact treatment program was often incomplete.

Results

Of 85 patients meeting the criteria of the study, follow-up information was obtained on all (100%). Follow-up periods ranged from less than one year to 11 years and date from the time of radiographically demonstrable healing. In the entire group there were 12 recurrences, or 14%; 86% had no recurrence during the period of follow-up. Inasmuch as the follow-up period varied, recurrence rate must be considered from the standpoint of duration of follow-up.

TABLE I

Period of Follow-up	Total Number Patients Followed This Period	% of Total Followed This Period	Number Recurrences This Interval After Healing	% of Recurrences
<1 Year	14	16.4	5	41.7
1-2 Year	19	22.4	2	16.7
2-3 Year	17	20.0	2	16.7
3-4 Year	11	12.8	1	9.2
4-5 Year	8	9.4	2	15.0
>5 Year	16	18.8	0	0.0
	85	99.7	12	99.3

Thus, while 75% of the recurrences occurred within the first three years after healing, 58.8% of the patients had follow-up periods of three years or less, and whereas only 25% of the recurrences occurred more than three years after healing, only 41% of the patients had follow-up periods of greater than three years. There would then appear to be some relationship between observed recurrence rate and duration of follow-up. It is interesting to note that no recurrences occurred after more than five years of healing, but this likely reflects the small number of patients in this group.

Age

In assessing the effect of age upon recurrence, age distribution for recurrent versus non-recurrent ulcers is given in the table below:

TABLE II

Age (by decade)	Recurrence	Non-Recurrence
10-19	0	2
20-29	0	2
30-39	2	3
40-49	2	15
50-59	3	19
60-69	4	23
70-79	1	4
80-89	0	3
90-99	0	1

Peak incidence for both recurrent and non-recurrent ulcer occurs in the 60-69 age group, and the distribution curves appear identical.

\* Beginning of diagnostic record coding.



Distribution by sex in the entire series is approximately equal, with males predominating in a 1.1:1 ratio (45 males:40 females). Of recurrent ulcers, however, three times as many occurred in males as in females. All recurrences, male and female, occurred in Caucasian patients, as opposed to none in Negro patients; however the ratio of white to colored patients in the entire series was 3.7:1.

#### *Influence of Location of Ulcer on Ulcer Recurrence*

Location of lesions as described by the radiologists is tabulated below, both for the entire series and for the recurrent ulcers.

TABLE III

Location	Entire Group	Recurrent Group
Pars Cardiac .....	1	0
P. Corpora .....	29	4
P. Antrum .....	19	3
Prepyloric .....	32	5
Lesser Curvature (Unspecified) .....	4	0
All lesser Curvature lesions .....	53	7
All greater Curvature lesions .....	2	0

It is apparent that distribution of the recurrent ulcers conformed generally to the frequency distribution of ulcers in the entire series.

#### *Effect of Duration of Symptoms Prior to Healing on Recurrence Rate*

Data was not always available or clear on this point; in four patients the duration of symptoms prior to diagnosis and treatment could not be ascertained; one record indicated symptoms for "most of life" in a 50-year-old male, and this patient was also noted to have a deformed duodenal bulb. In half of patients with recurrences, however, symptoms were stated to have existed for six months or less prior to diagnosis, ranging from "several weeks" to six months, averaging nine weeks' duration.

#### *Duration of Healing Time*

It is appreciated that the time between the initial x-ray examination demonstrating ulcer and a subsequent examination demonstrating healing need not always accurately reflect the minimal time required for x-ray healing, and that therapeutic programs differed; nevertheless, 50% of the ulcers which subsequently recurred had disappeared by x-ray within six weeks of initial diagnosis, and four (or 33%) within three weeks. The longest interval between first demonstration of ulcer and films indicating healing was ten months. Of the non-recurrent ulcer group, 12 patients had an interval of one year or greater between the two examinations.

#### *Influence of Associated Diseases and Medication on Recurrence*

In the entire group of 52 patients, 60.5% had

some concurrent disease process. Of the group with recurrent ulcer, eight patients or 66% had associated diseases, not a significant difference. If one considers only those diseases commonly associated with peptic ulcer disease, i.e., associated duodenal ulcer, hiatus hernia, pulmonary emphysema and rheumatoid arthritis, the incidence of these diseases was equal or higher in every instance in the whole group than in the ulcer recurrence group. Of other diseases, specifically active pulmonary tuberculosis, psychiatric disturbances and diabetes mellitus, there was one occurrence each in the recurrent ulcer group. Due to the difference in size of the two groups the slightly higher percentage incidence is not significant. This data is given in Table IV.

TABLE IV

Concurrent Diseases	Number of Cases (Entire Group)	Number of Cases (Recurrent Ulcer)	% Entire Group	% Recurrent
Hiatus hernia .....	17	2	20.0	16.7
Duodenal ulcer .....	11	1*	12.9	8.3
Pulmonary emphysema ..	9	1	10.6	8.3
Rh. arthritis .....	5	0	5.9	—
Diabetes mellitus .....	5	1	5.9	8.3
Psychiatric disorder ....	3	1	3.5	8.3
Diverticulitis .....	2	0	2.3	—
Arrested pulmonary tuberculosis .....	2	0	2.3	—
Active pulmonary tuberculosis .....	1	1	1.1	8.3
Acute pyelonephritis ...	2	0	2.3	—
Hypertensive vascular and cardiovascular disease .....	3	0	3.5	—

\* 1 patient had deformity of duodenal bulb.

Six patients in the entire group were receiving steroid therapy at the time of gastric ulceration. None of these patients developed ulcer recurrence.

### **Carcinoma**

One patient on whom the radiographic report stated ulcer disappearance was subsequently found to have carcinoma of the stomach. Review of the x-ray films on which the report of healing was based revealed not only persistence of the crater but was interpreted by an independent group of radiologists as probably representing carcinoma of the stomach. Thus, while human errors do occur, the patient cannot be said to have met the criteria of the study (radiographic healing) and was consequently excluded from the series. There has been no other incidence of carcinoma of the stomach to date in any patient followed and in none of the patients who had ulcer recurrence and subsequent gastric resection did the pathology report indicate anything other than benign gastric ulcer.

Ten of the cases studied are now dead. Only three



Healed Gastric Ulcer / Rossiter & Moore

of the deaths have occurred in patients who had ulcer recurrence and only one of these deaths was related to gastric ulcer, occurring three years and three months following initial healing. This patient had severe pulmonary emphysema and fibrosis and died following emergency gastric resection for bleeding gastric ulcer. Of the other two deaths in this group, one died one year and eight months after initial healing, the cause of death being listed as arteriosclerotic cardiovascular disease with cardiac insufficiency. Repeat gastrointestinal series during the week prior to death revealed "questionable ulcer, lesser curvature." The third patient who underwent subtotal gastrectomy for recurrent gastric ulcer, five months after the initial ulcer healing, died after five and one-half years from "bronchogenic carcinoma with generalized carcinomatosis." Of the seven remaining deaths in the non-recurrent ulcer group, five were due to cardiac disease, one to intracranial bleeding secondary to chronic myelogenous leukemia, and one to bronchogenic carcinoma and pneumonia.

Results in Patients With Non-Recurrence

The status of patients without evidence of recurrent ulcer was evaluated according to the presence of symptoms, need for medications, and occupational status.

- a) Excellent—no symptoms referable to stomach  
Not requiring medications  
Resumption of former occupation
- b) Poor—symptomatic, requiring medications, and/or not able to resume former occupation.
- c) Moderate—graduations in between.

Figures below show results in the non-recurrent group.

TABLE V

	Non-Recurrent	
	Number	%
Excellent .....	51	70.0
Moderate .....	16	21.8
Poor .....	6	8.2

Of the entire group, excepting the patients now dead (11), 27 have returned to work; 15 are housewives and can be considered to have resumed their former occupation. This represents 42 patients or 56% of the 75 living patients. Results in the non-recurrent group can then be considered quite good, with less than 10% of the patients having a "poor" rating. Of patients not now working, 16 are dead or retired. Occupational status on seven patients is undetermined.

Of the 12 patients with recurrence, seven have

subsequently had gastric surgery but two of these patients have since died. Of the five living patients who have had both recurrence and surgery only two are working. Of the four living patients with recurrences who did not have surgery, one is working. Three are neither working nor retired. Thus the incidence of vocational rehabilitation following recurrence was low, whether surgery was subsequently performed or not.

Discussion

In view of the well-documented evidence of a high percentage of serious complications and malignancy in chronic, intractable and recurrent gastric ulcers, surgical removal of these lesions would seem to be the most desirable course of therapy. On the other hand the acute or recent gastric ulcer can be expected to heal in the majority of instances, given appropriate medical therapy, and the over-all recurrence rate of such medically treated and healed gastric ulcers is not great, considering that objective proof of healing has been obtained. Of 397 patients with medically treated and healed benign ulcer in the Lahey Clinic series, 75% were considered to have a good result after follow-up periods ranging from two months to 29 years. In the present series recurrence occurred in 14% of the patients. Most of these recurrences appeared to occur within the first year after healing, but a significant number continued to occur throughout the first five-year period. The present study suggests that the recurrence rate may drop after that time.

In attempting to identify other factors which are determinates in gastric ulcer recurrence, age of patient, duration of symptoms and location of the ulcer crater appear to be of no significance. On the other hand the marked difference in sex distribution between the recurrent and the non-recurrent ulcers suggests that the male patient is most liable to recurrence in a 3:1 ratio. Although all recurrences in the present series occurred in Caucasians, the relatively small number of Negroes meeting criteria of the study make this finding questionable, and should perhaps be more extensively investigated. The low incidence of Negroes in this series may reflect socioeconomic factors making initial medical therapy less desirable and less practical than surgical measures.

It is of interest that in patients with concurrent diseases whose ulcer coincided with steroid therapy the recurrence rate was lowest and perhaps reflects stress factors and transient hormonal effects upon mucosal integrity. Conversely, the one death in the series which was related to ulcer recurrence was in a patient with severe pulmonary emphysema and perhaps indicated the effects of chronic and progressive physical stress in certain irreversible ulcer-linked ill-



nesses. Prognosis would seem therefore related to responsiveness of the underlying condition.

In assessing the value of different forms of therapy in the patient with simple acute gastric ulcer, there seems ample evidence, supported by this study, that given proper diagnostic study, medical treatment and follow-up study (with rigid insistence upon criteria of healing) the fear of malignancy need not be a serious consideration. Future behavior of the benign gastric ulcer should, on the other hand, be carefully assessed, and the likelihood of *initial* healing as well as the likelihood of recurrence following healing must both be considered and weighed. Obviously, economic as well as other factors, may sometimes prove decisive, but given optimal conditions, it would appear that one might expect healing, following intensive medical therapy, in 57-72% of patients, and of these healed ulcers no recurrence in 75-86%. Thus out of the original 100 patients, 52 may expect continued and probably permanent healing. Against the time and expense of intensive hospital medical management, under a 50% chance of permanent healing, must be weighed the immediate and long term risks and morbidity from surgery. In this perspective then, the relative merits and drawbacks of

both medical and surgical therapy may be properly considered by both patient and physician.

#### *Acknowledgements:*

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## MEDICAL SOCIETY PRESENTS CHECK TO ATLANTA ARTIFICIAL KIDNEY CENTER

The Fulton County Medical Society has presented a check for \$22,000 to the new Atlanta Artificial Kidney Center.

In ceremonies at the Academy of Medicine Dr. Lamar Peacock, Past President of the Society, made the presentation to Dr. Elbert Tuttle, Jr., Associate Professor of Medicine at Emory University, who will serve as director of the new facility.

#### Donations From Sabin Oral Sunday

The \$22,000 resulted from the 1964 Sabin Oral Sunday Campaign conducted by the physicians in Fulton County and coordinated from the Academy of Medicine building for an 18 county area around Atlanta. More than 700,000 doses of oral vaccine were given in Fulton County on six Sundays in the spring of 1964. Donations at the centers exceeded costs of the campaign and a special committee was appointed representing business, the press, and medicine to determine disposition of the surplus funds.

The "SOS" Campaign was one of the largest community-wide efforts of its kind ever undertaken in the Atlanta area. Numerous groups such as Jaycees, PTA's, news media, banks, the Board of Education, Health

Department, CDC, Pharmacists, Nurses, Civil Defense, Armored Express, Atlanta Advertising Agencies, John B. Daniel Drug Co., and many, many other groups participated in the Campaign. The entire project was underwritten by the Fulton County Medical Society.

#### Dramatic Drop

Following campaigns of this type the incidence of polio in Georgia dropped dramatically from 26 cases in 1963 to four cases in 1964 and no cases reported so far in the state in 1965. The goal of the local campaign was to eliminate polio in Atlanta.

The Artificial Kidney Center to be established at Grady Hospital will be a dramatic new addition to the city's medical facilities. Through the dialysis process which will be available at the Center, some kidney patients' lives will be saved who would otherwise have died.

The Special Committee which designated the Kidney Center as recipient of the SOS surplus funds was composed of Dr. John Yaeger; Dr. Albert Rayle, Jr.; Mr. Richard Hodges, Liller, Neal, Battle & Lindsay; Mr. Dale Clark, WAGA-TV; Mr. C. H. McNair, Trust Company of Georgia; Dr. Linton H. Bishop, and Mr. Opie Shelton, Atlanta Chamber of Commerce.



# CONGENITAL AMPUTATIONS, CONSTRICTIONS AND DISTAL SYNDACTYLY

Richard Torpin, M.D.,  
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■ Two cases are reported  
and discussed.

## REPORT OF CASES:

Case Report One, Talmadge Hospital No. 068-312. This concerned a well-nourished female infant of three months of age who was sent to the hospital following a single series of convulsions associated with a "cold." Her hemoglobin was 11.3 grams and encephalography revealed no abnormal change. Physical examination showed the following congenital abnormalities: rather deep narrow constrictions of the left forearm above the wrist (Figure 1), and of both legs above the ankles (Figures 2-3). In addition, there was congenital absence of the right great toe and distal phalanx-constriction of the next two toes which were joined together distally only. Figure 4 shows a probe in the opening at the base of the toes. The constrictions consisted of narrow circular depressions of the skin. In no case was the skin broken, but some constrictions extended nearly to the bone.

### No Expansion

Since these are rigid scar tissue rings they do not expand. As the growth in the extremity takes place, the constriction has a tendency to become deeper. Consequently, the ring of scar tissue must be excised completely to prevent its reformation. The operation

used is known as a Z-plasty as seen in Figure 4. This infant did not have clubbing of the feet.

The mother was 18 years old, 5 feet 8 inches tall and weighed 140 pounds. She had had one normal infant previously. At the seventh month in this pregnancy she fell on her abdomen but without bleeding or loss of fluid. She was attended in labor by W. C. Sams, M.D., of Ocilla, who stated that he noted no strings on the infant or on the placenta which was rather white and fibrotic.

Case Report Two, Talmadge Hospital No. 040-112. This concerns a four-year-old, well-nourished Negro boy who presented a complete cleft palate continuous with left side hare-lip. At birth he weighed about eight pounds and was said to have been born with one tooth erupting in the split upper jaw. In addition there was a wide-band, circular constriction of the right lower leg, midway between the ankle and knee (Figure 5C). Digits of the left side of his body were involved in amputations, constrictions and distal syndactyly. On the left hand (Figure 5A), the index finger was amputated below the nail bed of the distal phalanx, and proximal to this stump was a constriction at the same level as one on the middle finger.



FIGURE 1

Case One. Constriction of the right forearm above the wrist.



FIGURE 2

Case One. Constriction above the right ankle. Amputations constrictions and distal syndactyly of toes of right foot. No clubbing of the feet.





FIGURE 3

Case One. Double constriction above the left ankle. No clubbing of the feet.

For three days after birth these two constricted areas were joined by a fibrous band which gradually disappeared. On the middle finger there was also another constriction over the distal phalanx. Between the two constrictions on this finger was some fusiform swelling. There was marked bilateral talipes equinovarus deformity.

### History

The history was obtained from the mother, a slender woman 34 years old who had been married at 22. She had seven full term labors, all normal. One child died at three years of age due to chicken pox or complications; none was malformed. The subject of this note was the next to the last infant. Dr. Woods of Washington, Georgia (now deceased), attended the delivery in her home, and he made the remark that the cord was around the leg but made no observation about the examination of the placenta. The mother stated that about one month before term she was crossing a bridge and her feet slipped from under her on a frosty platform and she fell heavily. She did not consider herself seriously injured, lost no blood or fluid but thereafter, to term, she had pain in the lower abdomen, and the movements of the fetus caused discomfort such as she had not had prior to the accident. As to labor itself, which was at term and spontaneous, the mother stated that the membranes ruptured one morning and delivery took place late the same afternoon. As to the quantity of amniotic fluid she considered it to be normal and similar to her several previous labors.

Probably the cleft palate and hare-lip in this case have no relation to the other malformations.

Since 1937 more than a dozen fresh placentas have been studied exactly, all of which have been associated with fetal amputations, constrictions and frequently distal syndactyly. In each case there has been evidence that the amnion had been ruptured at some stage of the gestation. When the rupture takes

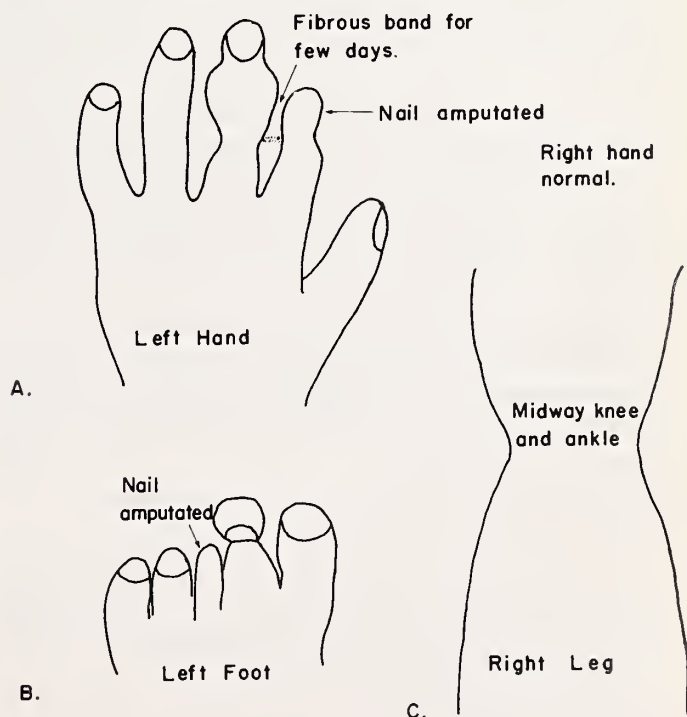


FIGURE 4

Case One. Photograph immediately following Z-plasty operation (removing the constricting scar tissue and to prevent recurrence). Note the probe in the sinus between the two distally agglutinated toes.

place, often associated with some degree of external trauma to the uterus, the fetus and amniotic fluid probably gradually emerge from the amniotic cavity into the surrounding chorionic cavity. As the detached amnion presumably slowly separates from the chorion, it has a tendency to detach shorter or longer fibrous strings which finally break, with one end still attached to the chorion and the other end to the outside surface of the free amnion. There is evidence that there may be more of these fine fibrous strings on the chorion over the placenta than on the chorion

### DIGITAL AMPUTATIONS AND CONSTRICTIONS LEFT SIDE ONLY



### BILATERAL TALIPES EQUINOVARUS DEFORMITY

FIGURE 5

Case Two. Amputations and constrictions of digits, limited to the left side of the body. Differing from case one, this had clubfeet.



of the membranes. This explains why the digits of one side of the fetal body may be the only ones affected, as in this second case. One side, for the main part, may lie towards the placenta and the movements of the arm and leg have a tendency to engage the toes and fingers with these one to three cm long hair-like strings. These are fragile and readily detached from the placenta but remain as circular constrictions around the digits. They usually do not cut through the soft tissues but prevent growth of the tissue cells directly under the constriction. When the bone of the finger or toe has increased its diameter to that of the constriction, all blood supply distally is reduced and the distal necrotic fragment is subject to traumatic fracture of the bone with separation. In other words, the subsequent fetal movements detach the fragment.

Longer and tougher strings that entwine the arms or legs may result from fragmentation of the detached amnion itself, and there are many case histories showing this to be the case.

### Association With Clubbing of the Feet

It has been postulated<sup>1</sup> that when the amnion ruptures and the fetus and fluid emerge into the chorionic sac that the chorion may allow absorption of the fluid to such an extent that the fetus is crowded, resulting in clubbing of the feet, as in Case Two. Reasonable as this may seem, it is only a hypothesis and as yet there is no proof for it.

From a personal experience of a dozen or more cases in which the fresh placenta and membranes were studied and from a perusal of five or six hundred case histories from the literature, it seems that clubbing of the feet may be more often associated with midterm rupture of the amnion. Early in the first trimester the arms and legs of the fetus may not protrude enough to be affected before the chorion toughens enough to retain the reformed amniotic fluid.

Late in the third trimester the arms and legs of the fetus may be strong and developed enough to withstand pressure to malform them. This is an impression and statistics have not yet been assembled to prove or disprove it.

### Hypothetical Consequences

The amnion is similar to the skin of the fetus which it joins at the umbilicus. It is clear, plastic-sheet thin, having five layers according to Bourne, 1962,<sup>2</sup> and on occasion the epithelium may change from a single cell layer to typical moist stratified epithelium. Once in 5,000 to 15,000 human pregnancies it, at any stage, may rupture without injury to the chorionic sac.

1. The disrupted amnion, totally or in part, slips

off of the chorion as the amniotic fluid and fetus emerge into the chorionic cavity. In so doing the amnion may detach shorter or longer mesoblastic fibrous strings from the chorion.

2. The amnion may remain as a sac near the cord-placental insertion, or it may fragment into sheets or bands, or it may roll up into a clothesline-like rope stretching across the chorionic cavity.

3. The fetus, then, is subject to having its fingers, toes, arms or legs, or other parts, neck, etc. entwined by either one or more of the fibrous strands or by the fragmented or rolled up amnion. This results in constriction bands leading to partial or complete amputation.

4. Not infrequently, and often before other possible damage to the fetus, the umbilical cord becomes entangled by the strings with strangulation, fetal death and eventual abortion. In many of these instances the cause of abortion goes unrecognized.

5. The fetus may swallow one of the free strand ends and, since the other end is usually attached to the placenta near the cord insertion, as the strand is drawn more and more into the gastrointestinal tract, the fetal head may be drawn up to and firmly held against the amnion-denuded placenta, where it may grow fast and produce a craniocerebral malformation. The string, sucked into the gastrointestinal tract, may have a tendency to press into the face with a resulting deep facial fissure leading upwards from the mouth orifice.

6. When the amnion remains as a sac, sessile to the placenta, or pedunculated, it is hypothetically possible that the fetus may extend an extremity through the rupture hole into the sac. As the fetus enlarges, the neck of the sac might bind the extremity and cause a constriction deformity. Such an amazing occurrence has been documented (Turner, 1960).<sup>3</sup>

7. It is reasonable to believe that, when the amnion ruptures, on some occasions the amniotic fluid would be absorbed temporarily by the amnion-denuded chorion. This situation is possibly the most important etiology of clubbing of the feet so often associated with these malformations. In addition, the temporary reduction in the size of the gestation sac may influence the production of abrasions or adhesions on projecting parts of the fetus as it moves about in the tighter fitting, denuded chorion.

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# PITFALLS IN THE DIAGNOSIS OF HYPOGLYCEMIA

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- One should proceed cautiously and unhurriedly in the diagnostic appraisal of a suspected case.

WHILE THE CLINICAL syndrome of hypoglycemia is well recognized by most physicians, the pitfalls of obtaining a precise etiologic diagnosis cause careful physicians to stumble sooner or later. The purpose of this paper is to alert physicians to the various diagnostic possibilities and to describe recent advances in the understanding of hypoglycemic mechanisms.

## Careful Documentation

Before proceeding, it should be emphasized that hypoglycemia must be documented by careful chemical measurement of blood or plasma glucose. All too often, the diagnosis is suspected on clinical grounds and never documented chemically. This is a mistake. States that may be confused with hypoglycemia include anxiety, depression, hyperthyroidism, and pheochromocytoma. Most of these can be readily differentiated by measurement of blood glucose.

Most students of hypoglycemia prefer glucose measurement by the Somogyi-Nelson, glucose oxidase, or the Autoanalyzer technique. Use of Dextrostix is easy and practicable but at all ranges of blood glucose, Alberti<sup>1</sup> reports that this diagnostic tool underestimates blood glucose concentration.

## What Blood Sugar Level?

What blood sugar level produces hypoglycemic symptoms? The answer to this question is not easy. Fasting blood sugar levels vary with age. In neonates during the first week of life, Cornblath<sup>2</sup> believes that hypoglycemia exists in full term babies only when the blood glucose is less than 30 mg.%; blood sugars of 20 mg.% or less in prematures are accepted as hypoglycemic levels during the first week of life. In adults, some physicians demand blood sugars of 40

or 50 mg.% or less before making the diagnosis of hypoglycemia. Others rely on the rapidity of the fall of blood glucose. When a rapid decline of blood glucose concentration is associated with hypoglycemic symptoms, then the diagnosis is made. Over 30 years ago, Walter Cannon<sup>3</sup> pointed out that the critical blood glucose threshold for hypoglycemic symptomatology tends to approximate 70 mg.% and *not* 50 mg.%. A recent study<sup>4</sup> of hypoglycemic reactions in normals and insulin requiring diabetics reported that hypoglycemic symptoms appeared at blood sugar levels of 288 mg.% ( $\pm 192$  mg.%) in insulin requiring subjects and at levels of 22 mg.% in normal controls.

## Pitfall Number One

*Hurrying.* In the evaluation of an hypoglycemic patient, the physician should approach the problem in an unhurried but concerned fashion. Hypoglycemia rings the islet cell adenoma bell in most physicians' minds. However, islet cell adenoma is a rare cause of the syndrome in adults and nearly unheard of in children. One should not explore the pancreas until the commoner etiologies of hypoglycemia are sought for and the diagnosis of adenoma seems certain.

The author remembers a 60-year-old Negro male who was admitted to the neurology service of a large teaching hospital with convulsions, fasting hypoglycemia and weight loss. Before a thorough evaluation of his problem was completed, laparotomy was done. No pancreatic adenoma was found and the distal two-thirds of the pancreas was removed.

The patient died postoperatively. Autopsy showed bilateral caseous adrenal glands. A needless operation and death could have been prevented if adrenal problems had been considered as a cause of hypo-



## HYPOGLYCEMIA / Dennis

glycemia in this patient. The pancreatic adenoma bell should ring, but the diagnostician should not be deafened by its sound.

### Pitfall Number Two

*Gastroenterostomies and Hypoglycemia.* Failure to recognize that gastroenterostomies may cause hypoglycemia as well as hyperglycemia may cause embarrassment and misdiagnosis. Gastroenterostomies produce an abnormally rapid absorption of glucose with early transient hyperglycemia followed by hypoglycemia. The ensuing hypoglycemia is related to the absolute hyperinsulinemia, stimulated by the early hyperglycemia, and second to the rapid depletion of intestinal glucose. This, then, really represents "insulin overshoot." The supply of plasma insulin outlasts the supply of glucose. A similar situation exists sometimes when I.V. glucose is suddenly terminated.<sup>5</sup>

A novel therapeutic maneuver aimed at connecting the troublesome hypoglycemia seen in gastrectomized non-diabetic patients has been proposed by Pankey.<sup>6</sup> He manages such patients with chlorpropamide in doses of 250-500 mg. per day. This keeps plasma insulin levels at relatively high levels and dampens pancreatic islet cell response to glucose loading. In this way wide swings in plasma insulin concentration are prevented.

Elrick et al.<sup>7</sup> as well as Dupre and Beck<sup>8</sup> and others have reported that plasma insulin response is greater following oral than intravenous glucose administration. Dupre and Beck have discovered an intestinal mucosal extract, biologically distinguishable from secretin, pancreozymin and insulin, which causes a significant reduction in the half time of glucose disappearance curves in normal men. Much remains to be learned about the inter-relationships between the intestine and islet cell function.

### Pitfall Number Three

*Failure to Consider Adrenal and Pituitary Causes.* The glucocorticoids play an important role in stimulating gluconeogenesis and maintaining glucose homeostasis. Patients with Addison's disease may demonstrate fasting hypoglycemia associated with normal levels of serum insulin. By blocking synthesis of cortisone, the principal glucocorticoid, enzyme defects in congenital adrenal hyperplasia may produce hypoglycemia. Roth<sup>9</sup> has recently demonstrated that hypoglycemia produces a prompt and sharp rise in serum growth hormone levels as measured by the radio-immunoassay technique. This helps explain the gigantism seen in hypoglycemic children. Growth hormone along with epinephrine, glucagon and glucocorticoids participates in hypoglycemic defense

mechanisms. Patients with Addison's disease and pituitary insufficiency are abnormally sensitive to endogenous or exogenous insulin and this fact was used by earlier workers in diagnostic study of these conditions. It should be reiterated that plasma insulin levels are within normal limits in such patients.

### Pitfall Number Four

*Failure to Suspect Diabetes Mellitus.* In 1956, Seltzer, Fajans and Conn<sup>10</sup> described spontaneous hypoglycemia as an early manifestation of diabetes. They noted hypoglycemia during the third to fifth hours of a five-hour glucose tolerance test in a group of early maturity onset diabetics. In this paradoxical situation, the insulin secretory response is delayed. Also, the blood sugar response to the secreted insulin is delayed. Hyperglycemia persists and continues to stimulate insulin production until the resulting hyperinsulinemia finally effects a breakthrough with consequent hypoglycemia.<sup>11</sup>

### Pitfall Number Five

*Failure to Perform Afternoon Glucose Tolerance Testing.* Roberts<sup>12</sup> has extended the observations of Seltzer, Fajans, and Conn in a group of patients who had definite hypoglycemic symptoms, but who demonstrated normal responses on routine morning five-hour glucose tolerance test by starting the 100 gram glucose tolerance test at noon, after patients had eaten a hearty breakfast and remained fasting until the test began. He was able to demonstrate concomitant diabetes and hypoglycemia. Patients who have clinical hypoglycemic attacks in the afternoon or evening are prime candidates for the afternoon glucose tolerance test.

A 32-year-old male patient seen recently is a case in point. He complained of tremulousness, sweating and hunger regularly at about 3 or 4 p.m. The attacks could be prevented or aborted by sweets. A sister had diabetes. There were no abnormal physical findings. Two morning glucose tolerance tests were normal. An afternoon glucose tolerance test showed a 60 minute value of 250 mg.%; 90 minute value of 220 mg.%; 120 minute of 198 mg.%; 180 minute of 90 mg.%; 240 minute of 52 mg.% (when the test had to be terminated because of hypoglycemic symptoms). A recent afternoon test gave similar results and symptoms. In short, it seems appropriate to do glucose tolerance testing so that the end of the five-hour test will fall about the time the patient's symptoms occur.

Pertinent to the discussion of afternoon glucose tolerance testing is Hayner's<sup>13</sup> elegant work showing that recent carbohydrate ingestion does not significantly alter the one-hour blood glucose value after glucose loading.



## Pitfall Number Six

*Failure to Recognize Inborn Errors of Metabolism.*<sup>14</sup> Congenital adrenal hyperplasia has already been mentioned. Other enzymatic defects causing hypoglycemia include glycogen storage disease, fructose intolerance, and galactosemia. Galactosemia (deficiency of galactose-1-phosphate uridyl transferase) is characterized by hypoglycemia, mental retardation, cataracts and hepatomegaly. Management consists of exclusion of all milk and foods containing galactose or lactose.

There are at least six different glycogen storage diseases and most of them are associated with hypoglycemia. The classic variety of glycogen storage disease, Type I or VonGierke's disease, exists when there is absence of glucose-6-phosphatase, necessary in the conversion of glycogen to glucose. Liver biopsy, epinephrine tolerance tests and glucagon tolerance tests help in the diagnosis of this condition. In managing the hypoglycemia associated with these diseases, Lowe and his colleagues<sup>15</sup> have found long acting zinc glucagon to be valuable.

In hereditary fructose intolerance, described first by Chambers<sup>16</sup> in 1956, intolerant individuals rapidly become hypoglycemic and manifested gastrointestinal disturbances after fructose ingestion. The primary defect is absence of the enzyme, fructose-1-aldolase. Fructose avoidance is the only management required. Elevated serum insulin levels are not found in fructose intolerance.

In leucine hypersensitivity, small amounts of leucine from dietary sources apparently stimulate release of islet cell insulin. The condition is primarily one of infants and children. Diagnostic testing is done by administering 150 mg. of leucine per kilogram of body weight. Blood sugars are drawn every ten minutes for one hour. In normal patients, blood glucose drops less than 10 mg.%, while a leucine hypersensitive individual's blood glucose falls to hypoglycemic levels. It must be pointed out that islet cell adenomas are often hypersensitive to L-leucine and the leucine tolerance test should be given to suspect individuals. Treatment consists of eliminating the amino acid offender from the diet.

## Pitfall Number Seven

*Failure to Suspect Ethanol and Liver Disease.* In the fasting individual who drinks heavily, ethanol inhibits gluconeogenesis and this is the mechanism of alcoholic hypoglycemia proposed by Frankel<sup>17</sup> and his colleagues. Liver disease probably contributes in at least two ways to hypoglycemia. First, glycogen synthesis is defective and depletion of this carbohydrate depot weakens hypoglycemia defense. Secondly, almost 50% of plasma insulin is removed by the liver during a single transhepatic circulation.<sup>18</sup>

Ordinarily the portal vein blood has a higher insulin concentration than does systemic. It is reasonable to assume that damaged livers remove less insulin from portal blood than normal ones.

## Pitfall Number Eight

*Failure to Consider Malingering and Psychopathic Behavior as a Cause.* Careful search of the patient's skin for needle marks and their belongings for hypoglycemic agents will reward the clinician's efforts in this group of patients. Fajans points out that the I.V. Tolbutamide test shows a diabetic response in insulin malingerers.

## Pitfall Number Nine

*Failure to Suspect Cancer.* Cancer has been recognized as a cause of hypoglycemia for many years. Mesenchymal tumors are the principal villains. Dispute still rages as to the mechanism of hypoglycemia in patients with cancer. Some feel the tumors consume inordinate amounts of glucose. Others think that these tumors produce insulin-like substances. Yalow and Berson<sup>19</sup> can find no increased immunologically reactive insulin in the tumors or plasma of such patients. Hypoglycemia due to cancer is rare.

## Pitfall Number Ten

*Forgetting About Idiopathic Hypoglycemia.* When one lumps together all the cases of hypoglycemia, there remains a sizeable number of patients whose hypoglycemia is idiopathic. In the pediatric age group this may approach one-half or three-quarters of the cases. Again, after all the causes of hypoglycemia are considered and nothing is found, the islet cell adenoma bell rings louder. The physician is tempted to have his patient explored. This should be done only if the patient has positive signs of islet cell adenoma. Pancreatic exploration should not be entered into lightly. When laparotomy is undertaken, the physician should be confident enough in his diagnosis of islet cell adenoma to recommend removal of the distal two-thirds of the pancreas whether a tumor is palpated or not.

Treatment of idiopathic hypoglycemia with Diazoxide® (Schering), an oral diuretic with marked hyperglycemic properties, has been evaluated in clinical trials. Its action seems to be in preventing insulin release by the pancreas.<sup>20</sup> It has proven useful in controlling hypoglycemia caused by metastatic islet cell carcinoma as well as in promoting euglycemia in idiopathic hypoglycemia. The drug has not been approved for general clinical use.

## Discussion

There is a need for orderly procedure in the unraveling of the causes of hypoglycemia. One should proceed cautiously and unhurriedly in the diagnostic



**HYPOGLYCEMIA / Dennis**

appraisal. Exploration for adenoma of the islets should be done only when there is good evidence of islet cell tumor and other etiologies have been excluded.

727 Juniper Street

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**NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA**

Connor, Robert T. Active—Floyd	Lindale, Georgia 30147
Hemphill, Roger A. Service—Laurens	VA Center Dublin, Georgia 31021
Kirkland, James J. Active—Laurens	Medical Center Dublin, Georgia 31021
Pauncey, Wyatt B. Service—Laurens	VA Center Dublin, Georgia 31021
Quenzer, Fred A. Service—Laurens	VA Center Dublin, Georgia 31021

**SHORT COURSE IN PROCTOSIGMOIDOSCOPY TO BE PRESENTED IN ATLANTA ON MARCH 3**

The Department of Surgery of Emory University School of Medicine in conjunction with the American Cancer Society is planning a short course in Proctosigmoidoscopy. This is to be given on Thursday, March 3, 1966, beginning at 1:00 p.m. in the Grady Memorial Hospital Auditorium. The various procedures, the newer instruments, and methods are to be discussed. The anatomical and the pathological processes are to be presented; demonstrations of the procedures are to be made, and a movie outlining the technical aspects is to be shown. Due to lack of space the registration will be limited. Those participating in the course are J. D. Martin, Jr., M.D.; J. Richard Amerson, M.D.; H. Harlan Stone, M.D.; John N. McClure, M.D., and Robert Smith, III, M.D.

**WORKSHOP IN RADIOISOTOPE SCANNING SLATED FOR APRIL 11-16 AT EMORY**

Emory University School of Medicine announces a five and one-half day workshop in principles, techniques, and interpretation of Radioisotope Scanning. This course is limited to individuals who have had previous experience with radioisotopes and who wish to add or extend scanning procedures to their diagnostic service. Participants will work with phantoms and patients on a variety of scanning units to develop famili-

arity with various units and various radioisotopes and the parameters of scan interpretation. Extensive teaching files will be available for study. A series of lectures covering principles, indications and interpretation of scans will be presented by a select panel.  
For further information contact: Joseph L. Izenstark, M.D., Division of Nuclear Medicine, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322.



# THE ALCOHOLIC AND HIS FAMILY PHYSICIAN

Ronald J. Catanzaro, M.D.,\* *Avon Park, Florida*

■ **Fullest use of already available treatment facilities is stressed.**

ANY MEANINGFUL discussion on alcoholism must begin by defining the terms alcoholic and alcoholism. An alcoholic is a person who has lost control over the use of alcohol and whose continued drinking, therefore, results in problems with his health, his job, his family and his friends. Furthermore, according to the American Medical Association, an alcoholic is a person who suffers from a chronic disease known as alcoholism. This disease is subject to remissions and exacerbations much like other chronic diseases such as asthma, peptic ulcer, etc.

## Four Distinct Phases

It has been shown by Dr. E. M. Jellinek that the disease of alcoholism progresses through four distinct phases. The *first phase* is called the prodromal or pre-alcoholic phase. Here the social drinker begins relieving everyday tensions of life by drinking and gradually begins drinking larger and larger amounts to achieve the same effect. In other words, the pre-alcoholic begins using alcohol as a drug to treat his "nerves" instead of a beverage one consumes on social occasions or with meals.

## Phase Two

*Phase two*, or the early alcoholic phase, is characterized by blackouts, sneaking drinks, preoccupation with drinking and consequently, development of marked guilt feelings about excessive drinking. The person undergoes a real personality change during this phase. In order to live with this new, strange, unlikeable alcoholic person he has turned into, he develops a characteristic elaborate set of alibis, or, as we call them in psychiatry, a system of defenses.

The three most prominent defenses which he develops are (1) Denial, i.e., frank denial that he has

a drinking problem; "I can take it or leave it alone." In reply to this, one must often ask, "Why is it, though, that you so often elect to take it even when taking it is ruining your life?" The alcoholic's well-known tendency to hide bottles and sneak drinks is a symptom of his attempt to deny being alcoholic. (2) Rationalization, i.e., he makes the illogical act of continued drinking, which is destroying him, seem logical. "I was tired and thirsty when I finished mowing the lawn on that hot summer day. When I opened the icebox and saw that cold beer, I knew that it was just what I needed." Question: "Why wouldn't a cold soda or ice water or glass of milk be just as effective in quenching your thirst?" (3) Projection, i.e., placing the blame for drinking on someone else. "My wife always nags me so much about drinking. If she'd just be quiet I wouldn't have to drink any more." Question: "Is there some change in your personality when you drink which gives her just cause for complaint?" These characteristic mechanisms of defense become well systematized in Phase II, and become ridiculously exaggerated in Phase III.

## Third Phase

The *third phase* of alcoholism is called the *crucial phase* and is characterized by a gross loss of control over the use of alcohol. It is during this phase that everyone who has any repeated contact with the alcoholic becomes painfully aware of the seriousness of this person's problem. It is called the crucial phase because the alcoholic stands in great danger of losing everything he holds near and dear to him (his family, his job, his friends, his health) unless he succeeds in arresting his illness.

Additional prominent characteristics of the alcoholic in this phase are (1) He exhibits grandiose behavior, i.e., he begins telling extravagant stories of phantasied great accomplishments in his life in order to cover up for his great feelings of failure and low self esteem. (2) He exhibits marked aggres-

Presented at the Georgia Academy of General Practice, Calloway Gardens, July 16, 1965.

\* Medical Director, Florida Alcoholic Rehabilitation Program, Chairman, Research Committee, North American Association of Alcoholism Programs



sive behavior as he convinces himself that all his troubles are due to his wife, his friends or his debtors. (3) He may well have periods of total abstinence to prove to himself he can "take it or leave it alone." Social drinkers do not need to undergo prolonged periods of abstinence as they do not need to prove to themselves that they do not have a problem. (4) He will change his drinking pattern to prove to himself that he has no drinking problem. For instance, he will switch to Vodka because he is led to believe Vodka will not smell on his breath. Or he resolves never to drink before a certain time of day. (5) He will change his associates as he convinces himself they are responsible for his problem. Thus he ends up divorcing his spouse and cutting off old friendships.

### Fourth Phase

The *fourth phase* of alcoholism is called the final phase. During this period the alcoholic goes on prolonged benders, usually loses everything near and dear to him, and finds himself on a grim roller coaster ride to prison, a state mental hospital, or death from a complication of drinking. Ray Milland depicted this phase well in his movie of the 1940's called "The Lost Weekend." The popular concept of an alcoholic is actually a person in this fourth and final phase of the illness. It is well established that if an alcoholic can have his illness diagnosed and treated before he reaches this fourth phase, i.e., while he still has his family, job and health, he stands a much greater chance of recovering.

One will find working with alcoholics extremely frustrating and unrewarding unless he thoroughly grasps this concept, that *alcoholism is a disease in and of itself*, not just a symptom of another illness or a sign of being weak-willed and a moral jelly-fish.

### The Cause?

To further our understanding of the disease concept of alcoholism we must ask, "What is the cause of this disease?" Although no one pretends to completely understand the etiology of alcoholism, we do know a good deal about the subject. Various combinations of three major factors appear to be involved in causing a person to drink excessively. The first factor is personality problems which are in part a propagation of personality problems in the family group which raised the person from a child. The second factor is heavy environmental stresses whether they be problems at his place of work, with his marriage, his social life or his health. The third factor is social customs which condone heavy drinking.

Any combination of these three factors, i.e., personality problems and/or heavy environmental

stresses and/or socially condoned heavy drinking leads to excessive drinking. Excessive drinking in combination with an unknown factor of abnormal physiology, i.e., an ex-factor or an addicting factor, leads to alcoholism. Although this scheme is unproven, it provides the therapist with a useful framework for understanding the alcoholic patient who appears before him for help.

If you are now able to consider alcoholism in terms of being a disease and are willing to tentatively accept the above outlined theory of its causation, you might now say, "So what? I rarely see an alcoholic in my practice!" To this I would have to reply, "You are absolutely wrong!"

### Loss of One Billion Dollars

The National Council on Alcoholism after many years of study of the problem of alcoholism in industry estimates the annual loss to big industry alone in the United States because of alcoholic employees to be over one billion dollars. That averages out to about 20 million dollars loss per state. Former Secretary of Health, Education and Welfare, Anthony Celebrezze, has stated that, "Alcoholism is our fourth major health problem." There are six million alcoholics in the United States—one out of every 33 Americans is an alcoholic. Each of you in this room, if you can count 33 persons in your relations, has statistically one alcoholic in your own family; and certainly if you have more than 33 patients in your practice you statistically have at least one alcoholic patient.

We are now at the point where you must ask, "What can we do about our alcoholic patients?" The other speakers on this program will have much to say about this area. I wish only to state four general principles of treating the alcoholic which have proven to be most helpful.

### To Make the Diagnosis

The *first rule* is to *make the diagnosis of alcoholism* when it exists. One should begin suspecting alcoholism in any patient that comes complaining of a *common complication of alcoholism*. It is the minority of alcoholics who first come for medical care complaining that they are an alcoholic. Rather, their complaints fall into five categories:

1. Gastro-intestinal symptoms, i.e., peptic ulcer, gastritis, hematemesis, chronic indigestion, pancreatitis, cirrhosis and hemorrhoids.

2. Orthopedic symptoms, i.e., multiple fractures of mysterious origin, commonly of the ribs, arms and skull. This may be the result of one of the occupational hazards of drinking—falling from a high bar stool.

3. Neurological symptoms, often vague in character, i.e., blackout spells, amnesia, peripheral neuritis,



chronic brain syndrome, Korsakoff's and Wernike's Syndromes.

4. Psychiatric symptoms, i.e., nervousness, depression, loss of sexual drive, promiscuity, homosexuality, suicide attempt, insomnia.

5. Social maladjustment symptoms, i.e., increased marital discord, failure to advance on the job, failure to get along with associates.

### One's Attitude

The *second rule* of successful treatment is that the physician must have a *constructive, knowledgeable and optimistic attitude* toward the alcoholic. One must realize that the alcoholic can be helped and is being helped every day. Any professional who has specialized in treating alcoholics can give you a long list of patients of theirs who have ultimately attained continued sobriety since treatment. Treating the alcoholic can be a very rewarding endeavor for both the physician and the patient.

### 100% Abstinence

The *third rule* is to insist on 100% abstinence *from alcohol*. It is a mistake for the physician to focus initially on finding the "cause" for the patient's drinking with the idea in mind that once the cause is uncovered and understood, the drinking will stop automatically.

It is safe to assume that the alcoholic has not only the initial "problem" which caused his alcoholism be it sociologic, psychologic, etc., but also has in addition, another problem, that of addiction to alcohol. To treat the alcoholic one must focus on the problems in the reverse order in which they developed, i.e., initially one should focus one's efforts on achieving 100% abstinence from the use of alcohol,

and then gradually shift emphasis to the problems which appear to underlie the alcoholism. The more successful the patient is at completely abstaining from the use of alcohol, the easier it will be for the patient and the physician to understand and correct the problem areas which may have given rise to the alcoholic problem initially. It is important for the physician to be prepared to accept the fact that the alcoholic rarely achieves continuing sobriety the first time his physician recommends it. Each time the patient resumes drinking the physician must explore with him the factors which led up to the resumption of drinking and with this knowledge must help him work out alternative realistic solutions to "solving his problems" instead of resuming drinking to avoid solving them.

### Utilization of Resources

The *fourth rule* is to *utilize all community resources* which you can bring together to help you in your treatment of the alcoholic. Useful community resources are your state or local governmental alcoholic rehabilitation program, Alcoholics Anonymous, the local Council on Alcoholism, local physicians and clergymen who are specially interested in the alcoholic, and the local alcoholic half-way house. Most every community will have one or more of the resources available, and it is your responsibility to familiarize yourself with them.

In summary, the problem of alcoholism in medical practice is gigantic, but the tools to successfully treat alcoholics are available. We must all cooperate to see that these tools are used to the fullest extent possible.

P. O. Box 1147

## FULTON COUNTY MEDICAL SOCIETY HOLDS 61ST ANNIVERSARY BANQUET

Dr. John T. Godwin was installed as President of the Fulton County Medical Society at its 61st Anniversary Banquet held on January 6 at the Marriott Hotel.

More than 400 persons—doctors, their wives and guests were assembled in the Grand Ballroom when Dr. Lamar Peacock, retiring President, called the meeting to order. The Rev. Eugene Drinkard gave the invocation, and Dr. Peacock introduced guests. Following installation of officers by Dr. Peacock, Dr. Godwin delivered his inaugural address titled "The Omens" in which he urged physicians to "accept the inevitability of change and beginning now, accept the challenge of change and attempt to mold it in a way which you believe will enable us to continue to provide the best medical care ever devised, in the way which you wish it to be delivered."

Guest speaker for the evening was Dr. Charles L. Hudson, of Cleveland, Ohio, President-Elect of the

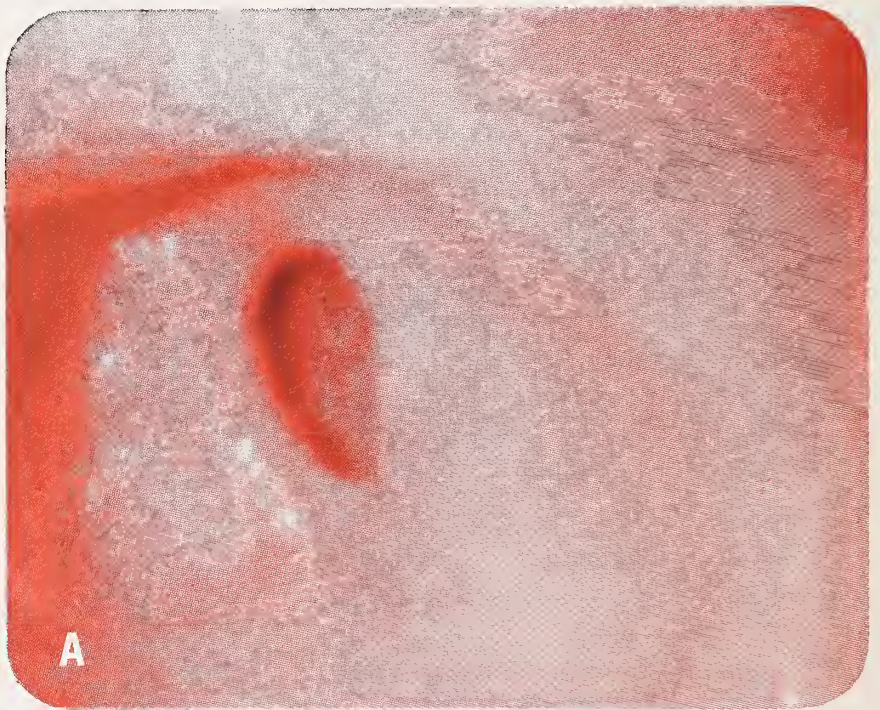
AMA, whose subject was, "How Medicare Will Affect Your Practice," explaining the role of the AMA in advising physicians of the rules and regulations of the Medicare law.

Dr. McClaren Johnson presented the President's Scroll and Key to retiring President, Dr. Lamar Peacock.

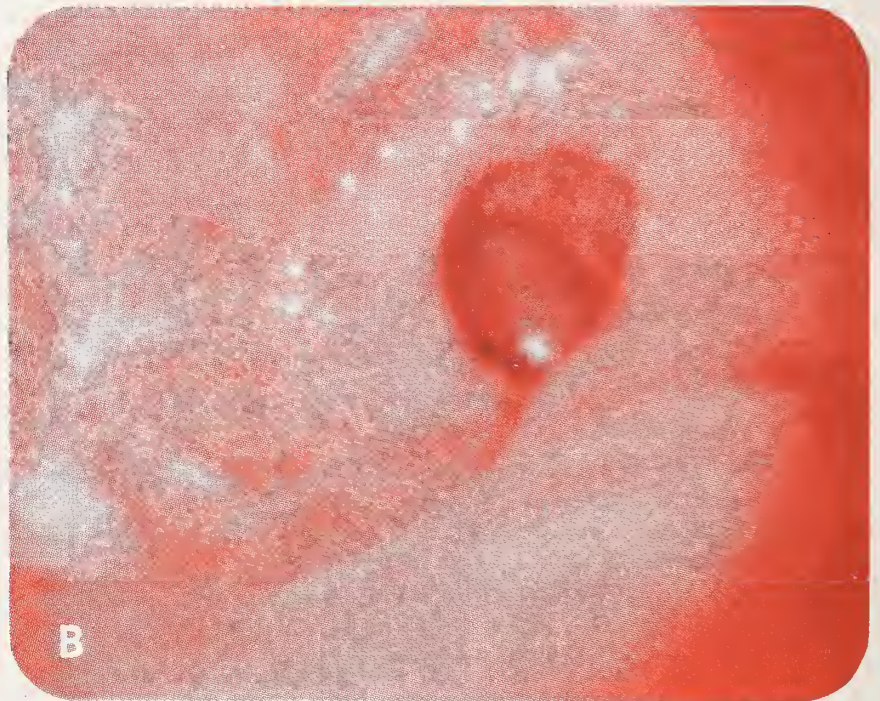
Dr. Carl C. Aven was the recipient of the coveted Citizenship Award Cup which was presented by Dr. John T. Yauger. The Award is given for outstanding contributions to the community in the fields of welfare, education, health, governmental boards and the arts.

Dr. Godwin recognized 16 physicians who have 25 years of continuous membership in the Society, two who have 50 years and seven who were granted Life Membership during 1965. All Past Presidents in attendance were also honored.





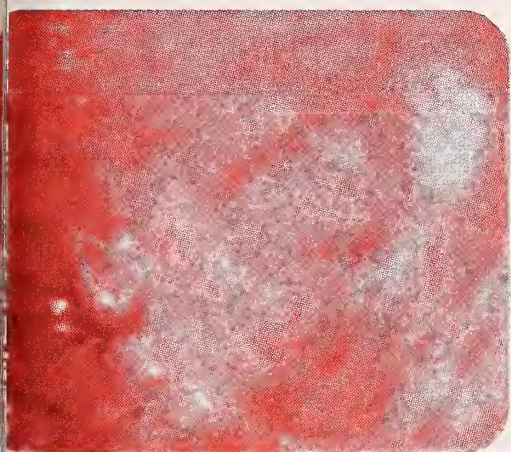
*Which Is Pyloroplasty with Vagotomy?  
Which Is Pro-Banthine?*



Photographs—Harry Barowsky, M.D., Lawrence Greene, M.D., and Robert Bennett, M.D., from a Scientific Exhibit presented at the Annual Meeting of the American College of Gastroenterology, Bar Harbour, Florida, Oct. 24-27, 1965.



# Another example of Pro-Banthine® (propantheline bromide) a true anticholinergic in action



Normal relaxed pyloric antrum; contracted pylorus (pyloric fleurette)

The true anticholinergic values of Pro-Banthine have never been so graphically realized as they are with the recent development of fibergastroscopy and the intragastric camera.

Pro-Banthine consistently produces complete relaxation and immobility of the stomach with a dose of only 6 to 8 mg. intravenously. This is less than half the usual dose orally.

Atropine, on the other hand, required 0.8 mg. intravenously, or twice the normal dose, to achieve a similar effect. This high dose of

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Pro-Banthine, in minimal dosage, produces effects similar to pyloroplasty and vagotomy without the disadvantages of permanent post-vagotomy sequelae.

The intragastric photograph A is of a patient who has had pyloroplasty with vagotomy. Photograph B is of a patient given 6 mg. of Pro-Banthine.

**Indications:** Peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

**Oral Dosage:** The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

**Side Effects and Contraindications:** Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. Pro-Banthine is contraindicated in patients with glaucoma, severe cardiac disease and prostatic hypertrophy.

**SEARLE**

*Research in the Service of Medicine*



# For Your MAG 1966 Annual Session Hotel & Motel Reservations

## APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS

Medical Association of Georgia 112th Annual Session

May 8-10, 1966—Columbus, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Columbus for the 1966 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodation information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure; (3) names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Housing Bureau. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible to secure the accommodations you request. All reservations will be confirmed.

**Ralston Motor Hotel, Inc.:** 12th Street and 2nd Avenue (322-7331) 250 rooms; **Single \$6 to \$8; Double \$8 to \$10; Twin \$9 to \$12;** air conditioned; television and background music; Coffee Shop and Dining Room—open 6:30 A.M.-11:00 P.M.; Chart Room Lounge for Lunch and Beverages—open 11:00 A.M.-1:00 A.M., downtown Columbus.

**Martinique Motor Hotel:** 1011 4th Avenue (322-6641) 198 rooms; **Single \$8 to \$10; Double \$11 to \$13; Twin \$13 to \$16; Deluxe Studio Rooms \$13 up;** air conditioned; background music; TV in every room; room telephones; two restaurants; swimming pool; Grand Prix Lounge; package store on premises; barber shop; valet laundry service; downtown Columbus.

**Downtowner Motor Inn:** 1325 4th Avenue (322-2522) 99 rooms; **Single \$8 up; Double \$10.50; Twin \$12; Suites \$18 up;** air conditioned; background music; TV in every room; room telephones; 24 hour switchboard; restaurant 6 A.M. to 10 P.M.; swimming

pool; steam room—massuer; Boar's Head Lounge; package store on premises; downtown Columbus.

**Heart of Columbus Motel, Inc.:** 1024 4th Avenue (324-3694) 42 rooms; **Single \$7; Double \$9; Twin \$11;** air conditioned; room telephones; adjoining restaurant; TV in every room, downtown Columbus.

**Holiday Inn of America:** 3170 Victory Drive (689-6181) 184 rooms; **Single \$7 and \$8; Double \$9.50; Twin \$11 and \$12.50; Executive Room \$12.50;** air conditioned; TV in every room; background music; room telephones; restaurant; swimming pool; 3 miles from downtown Columbus.

**Howard Johnson's Motor Lodge:** 3181 Victory Drive (689-7580) 50 rooms; **Single \$9 and \$10; Double \$10; Twin \$12; Family Units \$14 to \$16;** air conditioned; background music; TV in every room; room telephones; lounge; swimming pool; putting green; Howard Johnson's Restaurant next door; 3 miles from downtown Columbus.

*Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made. Deposit of one day's room rent will be required with each request for accommodations.*

Cut out and send to:

Please Type or Print

HOUSING BUREAU, MEDICAL ASSOCIATION OF GEORGIA

Ralston Motor Hotel, Columbus, Georgia

Please reserve the following accommodations for the 1966 Annual Session of the Medical Association of Georgia.

### Hotel or Motel Preference

1st Choice .....	<input type="checkbox"/> Double Room at \$..... to \$.....
2nd Choice .....	<input type="checkbox"/> Double Room at \$..... to \$.....
3rd Choice .....	<input type="checkbox"/> Twin Bedroom at \$..... to \$.....
	<input type="checkbox"/> Other Type .....
Arrival Date .....	Hour ..... A.M. .... P.M.
Departure Date .....	Hour ..... A.M. .... P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include all names of all persons for whom you are requesting reservations and who will occupy the room(s):

Name of Occupant(s)

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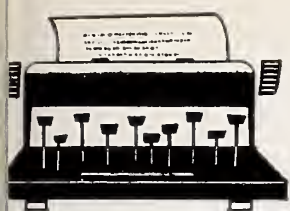
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*If hotels or motels of your choice are unable to accept your reservations, the Housing Bureau will make reservations to fit your specifications elsewhere.*





## The Development of an Idea The Mesh Skin Graft

**S**ELDOM does an opportunity exist for an observer to follow closely the progress of an idea, as it develops, skillfully evaluated by proper research methods, to ultimate fruition. Especially, an effort that rapidly brought benefit to over 250 patients.

To surgeons, particularly those responsible for the care of major burns, the advent of a dermatome for preparing mesh skin grafts has been most important. A distinct provincial flavor ensues, because the machine and its clinical use was the singular result of the endeavor of one of this association's own members.

### An Intriguing Method

As early as 1958 the chief investigator became intrigued with methods for increasing the benefit of donor skin by dispersion particle technic to cover large areas. Mechanisms developed by others appeared to be cumbersome and not too rewarding. In February of 1963, in controlled experiments, utilizing various mechanical devices and different sized skin particles, it was proven that good results could be obtained.

A radical departure in experimental technics occurred in June, 1963, when the investigator believed that the principle of area expansion, so familiar to those producing expanded sheet metal, could also be applied to donor skin. A more familiar analogy, to many perhaps, is the area expansion accomplished by an old-fashioned folding-type wooden gate so frequently used to guard young children from dangerous stairways. Within a few days, the surgeon, teamed with an engineer and a resident in plastic surgery, developed a prototype device that would cut slits in a piece of donor skin so that when it was stretched (as the wooden gate), it would cover three times its original surface area. The summer was spent in the laboratory, improving the device and obtaining consecutive satisfactory results in animals. After statistically significant results were obtained, the dermatome was used successfully for the first time on a human, whose burn problem became the

source of the first clinical presentation.<sup>1</sup> Shortly thereafter, pilot machines were built for large burn centers in Detroit and Chicago. When further good clinical results were obtained with the original three machines, others were built for use in some other cities, and also loaned to two Atlanta surgeons.

### Interesting Facts

Further assessment of this study reveals other interesting facts. The research work was done by a busy clinical surgeon at his own personal expense (without grant-in-aid or other subsidy). The animal work was conducted in the surgery suite of a local veterinarian. Certainly this is unique today, when one is accustomed to hearing of developments from multi-disciplined research centers supported by Federal grants.

The Meshgraft® Dermatome was recently described pictorially in a national lay magazine.

It further exhibits the principle that personal enterprise and a varied interest (surgeon, engineer and resident plastic surgeon) can achieve a most successful result. The benefits of the technic and equipment are familiar to those who have had an opportunity to use the mesh dermatome. The results in 250 patients (to be published) speak for themselves.

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## Solving the Communications Bottleneck

IT HAS NOW become apparent that the rules and regulations to be promulgated for the new Medicare law (P.L. 89-97) will flow forth with some regularity during the month of February and thereafter. It also may be said that new information on other programs involving health care will soon be available, such as the Dependents' Medical Care Act (military medicare), the V.A. program, the Adult Recipients Medical Care program, Community Mental Health programs, Areawide Hospital Planning-Utilization Committees, etc.

### Means of Communication

So that the Association may perform its responsibility of communicating these matters to its physician membership, the Association will endeavor to use the *MAG Journal*, the County Society Officers Newsletter and personal all-member communications to each doctor. In addition to this, MAG meetings are being planned for County Medical Society participation to provide the latest information on these and other related subjects.

To solve what might become a "communications bottleneck" in the few months before some of these

programs become effective, it is urged that you pay especial attention to MAG letters and your *MAG Journal*. While there is scant information at this time, it is believed it will all come at once. It is advised that you look for the MAG letterhead as it is received in your office. It is also advised that you scan the contents of the *MAG Journal* in the ensuing months and that your County Medical Society review the MAG newsletters as they are received by your society officers. It is also well to remember that on the national scene, the *AMA NEWS* will probably provide the most timely information in that it is published weekly.

### "The Word"

Again, and it bears repeating so that the process of communication can be carried on—it is our suggestion that you alert your office secretarial assistants to put those letters on MAG letterhead in the top-of-the-mail-pile in an effort to get "the word" on these programs.

In a changing world we are all too busy, and it is most difficult to really keep abreast. Therefore, we emphasize that between now and July 1, all physicians make a special effort to read their mail.

## Medicare—A Storm Warning

MEDICARE is law and the most elemental fact in existence is that physicians don't like it.

The medical profession is not alone in its low regard for the medicare act, nor was the profession alone when the program was adopted. Most opinion polls conducted prior to enactment clearly indicated that the public had grave misgivings bordering on outright opposition. Yet the Congress voted to chart the treacherous waters of government controlled medicine and launched its canoe on a course that could have but one ultimate destination—medicare for all ages.

### Few Swayed

Why, one asks? Why, in the face of such substantial opposition did the Congress insist on such

a massive answer to such a limited problem? Were there no sensible alternatives? Was Congress overwhelmed by the force of "logic" articulated by the Administration and other proponents of this program? Possible, of course, but only the naive believe it. In retrospect it is clear to see that only very few Members of Congress were swayed by the debate on this issue either one way or the other.

The truth of the matter is that a commanding majority of those who voted for medicare had every intention of doing just that from the moment the election returns were in following their campaign of Fall, 1964.

Simple logic would lead us to believe, therefore that the best defense possible against the enactment of medicare would have been to take definitive mea-



ures assuring the defeat of many of those candidates known in advance to support this program.

## 20/20 Hindsight

Some will say that this is 20/20 hindsight and a glimpse of the future through a rear view mirror is something less than accurate. This naturally raises the question, how will medicine guard against a reckless expansion of the medicare concept when we all know that pressure to expand the program is already brewing?

The answer is simple. Organization. Organization that will give us the power to help determine the political complexion and philosophical makeup of the next Congress.

Such an organization does exist. Your medical political action committee; GaMPAC and AMPAC exist for this purpose and this purpose only. It can do the job of helping to restore common sense to the

Congress. It cannot do it, however, without the support—money and time—of the members of the medical profession. It possesses no magic. It possesses only good organization, know-how, and a determination to see the job accomplished.

## "Nothing Yet"

If you don't like the Social Security medicare idea, then in the words of the late Al Jolson, "you ain't seen nothing yet." The appetite of those who support this type of legislation is insatiable. Ignoring the matter will not cause it to go away. Matters will not get better; they will get worse if you choose to do nothing.

Our best long range defense against the continued expansion of the medicare concept lies in the perfection of a well-oiled, efficient and more effective political action organization. GaMPAC is that organization. If you want it you most surely can have it.

## DISABILITY EVIDENCE ELICITED THROUGH NARRATIVE REPORTS, TELEPHONE QUERIES

The social security disability program has recently changed from their old questionnaire type form. In the future, physicians will be asked to give a narrative report on a patient's condition. It is expected that this will simplify the physician's task and at the same time give valuable information to the agency.

These developments have been announced by Dr. George B. Dowling, medical consultant of the Georgia agency of the social security program.

### Replacement of Questionnaire

Physician preference led to the replacement of the old style questionnaire. Studies carried out in six states demonstrated that doctors could give a clearer, more concise clinical picture of a claimant by using a reporting format that comes as second nature to most physicians. As a result, the disability program is introducing nationwide a revised form designed to provide ample space and a more effective format for detailing the patient's history, physical and laboratory findings.

If additional data is needed for an evaluation, the reviewing physician at the State agency may call the reporting doctor's office and request further information. If such is available from the patient's record this information may be given by telephone. If the reporting physician happens to be busy when the call comes in, he may return the call at his convenience.

Experience shows that such telephone calls generally take under five minutes. In states where this technique has been tested, reporting doctors volunteered the opinion that they prefer such calls to letters of inquiry. Also doctors said they welcome the chance to discuss the case with colleagues at the state agency.

## AMA RURAL HEALTH CONFERENCE SCHEDULED MARCH 18-19

Farm and health leaders will meet March 18-19 at Colorado Springs for the 19th National Conference on Rural Health.

The meeting in the Broadmoor Hotel is sponsored by the American Medical Association's Council on Rural Health together with state medical associations, farm, educational, and allied health organizations.

W. Wyan Washburn, M.D., Chairman of the Council on Rural Health, described the purposes of the Conference as:

- To improve methods of communication in health education for rural people.
- To more fully understand and be able to utilize more efficiently health manpower resources in a community.
- To assess the effect of environmental factors on the health, safety and well-being of people living in rural areas.
- To discover and be able to implement the utilization of community health resources.

Following an address by Governor John A. Love of Colorado, the sessions on the 18th will feature programs to meet health manpower needs, guidelines for better communication, and water pollution control measures in rural areas. The program for the 19th will be highlighted by breakfast discussion groups on a wide range of health subjects, a talk on rural accident prevention, and a review of the work of the National Commission on Community Health Services.

Marion D. Hanks, LL.B., of the Church of Jesus Christ of Latter-day Saints, will speak on the subject "What Rural Youth Needs Today" at the banquet session on Friday evening in the International Center.





## THE APPROACHING ANNUAL SESSION

AS THIS is being written, my good wife and I are alone at home on the night after Christmas. Our son and his family have departed. We all talked to our daughter and her children in Texas—with mixed emotions because they couldn't be here, but glad that they didn't have to be on the highways. All in all, it was a wonderful Christmas, with much fellowship with family and friends—many gifts but, as usual, too much food.

### Not Too Soon

By the time this reaches the printed page, about six or seven weeks hence, it will not be too soon for you to begin making your plans to attend the Annual Session to be held in Columbus, May 8-10.

Your Board of Annual Session has already put many hours of work into planning this meeting along with the help of the Program Chairmen from the various sections and the Local Committee on Arrangements. Much more work will be done between now and May 8 when the meeting opens at 2:00 p.m.

Sunday afternoon from 2:00 to 5:00 p.m. there will be eight Joint Section meetings—all held simultaneously. At 5:00 p.m. there will be the first General Business Meeting—chiefly for the nominations of new Association Officers. This will be followed at 6:00 p.m. by the Medical Schools' Social Hours and Dinners.

Monday the 9th at 9:00 a.m., there will be the Joint General Business Session and House of Delegates Meeting—to be followed at 10:30 a.m. by a program devoted to "Medicare" or Public Law 89-97. At 12 noon there will be a program arranged by the Georgia Medical Political Action Committee (GaMPAC).

Monday at 2:30 p.m., the General Scientific Session will be devoted to Geriatrics, featuring three outstanding speakers of national prominence. The only other official activity at this time will be the meetings of the Reference Committees of the House of Delegates.

At 6:30 Monday evening, the Muscogee County Medical Society will entertain at a social hour to be followed at 8:00 p.m. by the President's Banquet. Word has been received from the Local Arrangements Committee that you can look forward to very good entertainment for this occasion.

Tuesday the 10th there will be a Joint General

Business Session and meeting of the House of Delegates opening at 9:00 a.m. This session will conclude the 112th Annual Session.

### Changed Format

You will note from the foregoing that not only has the format of the program been considerably changed, but that the total span of the Session is being shortened by a full day. This change might be considered a trial balloon and much credit is due Dr. Spitzer, Annual Session Chairman, and his Board. It is hoped you will like these changes and that its approval will be manifest in that more of you will not only come, but that you will stay for the entire meeting.

There has been some apprehension on the part of the Annual Session Board, the Executive Committee and Council that we might be "on the hook" because of the fact that the meeting begins on "Mothers Day." We realize that some of you do not like to be away from your homes for a meeting on that occasion, and we are sorry that circumstances prevented the meeting from being a week earlier. The plan was for a week earlier, and then it was found that the Auditorium was tied up by the Boy Scouts for that date and had been for a number of years. It was too late to do anything about it. It is hoped that this explanation will get us "off-the-hook."

### Begin Making Plans

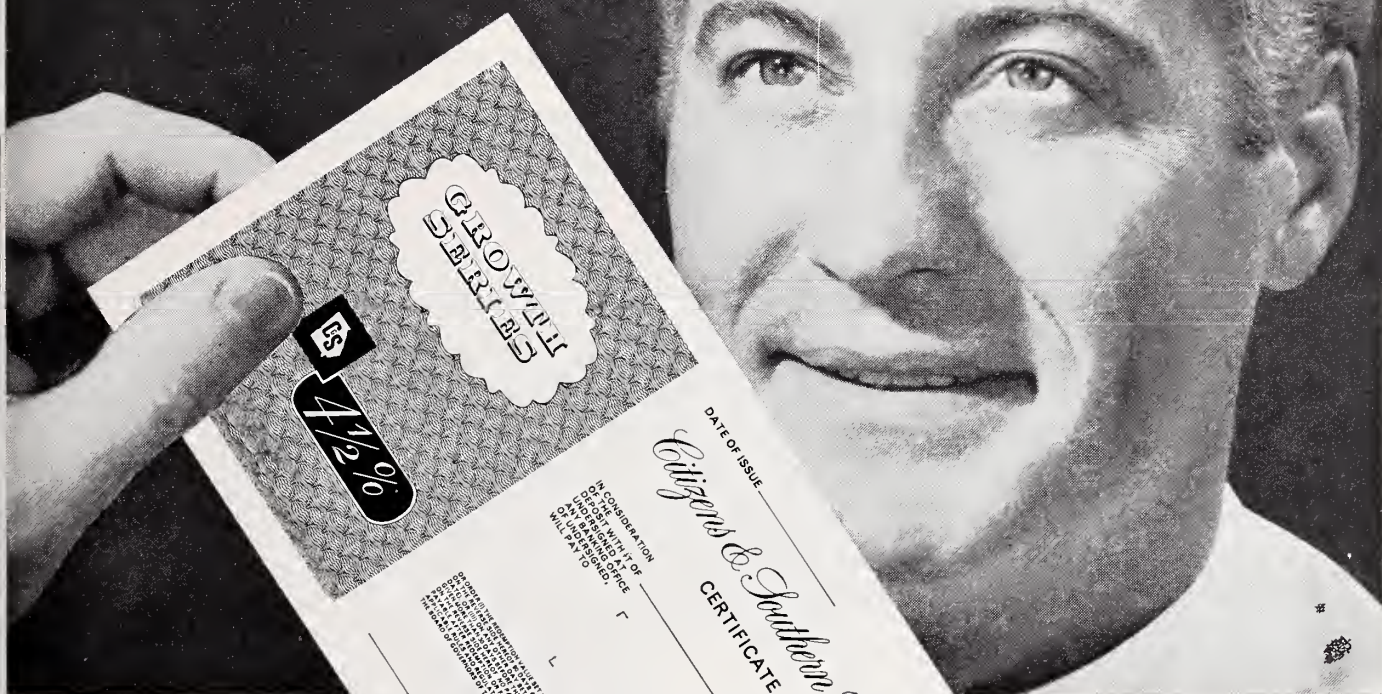
So, begin making your plans for you and your wife to be in Columbus, May 8-10. You will have an opportunity to attend meetings at which valuable scientific information will be made available to you. I know, too, that most of you will enjoy and be very interested in the 10:30 a.m. Monday program at which time Medicare and other socio-economic matters will be discussed. This information should be most valuable to you. Besides that, the opportunity to see again many of your colleagues and to fraternize with them should be another strong incentive. Will be looking forward to seeing you.

George H. Alexander, M.D.  
President, Medical Association of Georgia



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### MAMMOGRAPHY—GOOD OR BAD?

A. H. Letton, M.D., *Atlanta*

AS A RESULT OF Dr. Robert Egan's efforts in developing the "standardized technique," mammography is finding an increased popularity among physicians and laymen. The technique calls for a special x-ray machine, usually with the range of 20 to 35 KVP. Thus, the usual equipment must have a modification of the transformer circuitry to take adequate mammograms. Since mammography is a form of diagnosis which is an expression of judgement on the part of the examiner, he must have training and experience to render reliable opinions.

#### Dubious Accuracy

Some 300 radiologists now report an accuracy of 79%, which is really very good unless the 21% inaccuracy is in your patient or wife or daughter. This 21% is reported to include a fair number of clinically palpable cancers which cannot be identified on mammography no matter how good the films. The greatest source of error is in the patient with the so-called dense breasts. Unfortunately, this is where it is needed the most. These patients are usually in the menopausal or premenopausal group where the involution of the breast is incomplete and various forms of disease are common. This, many times, will obscure small carcinomas. Certainly carcinoma can be seen in some of these breasts but, nevertheless, the dense breast impairs the diagnostic acumen of the procedure.

In a smaller group of people with intraductal carcinoma there may be an absence of calcification which makes it very hard, if not impossible, to recognize the malignancy. The small carcinomas near the periphery of the breast also, at times, are difficult to visualize.

#### Where Is It Useful?

Where, then, is it useful? It certainly is not a histological method and in no manner replaces the traditional methods of breast evaluation for certainly if the mass is clinically suspicious it should be

biopsied. It cannot be relied on to rule in or rule out malignancy of the breast except as it adds evidence to the clinical impression already at hand to help in a diagnosis. Its greatest help then, is where the clinical examination is difficult and this added bit of information is of real value. This is where it should be utilized.

#### In Doubt

The effectiveness of the use of mammography as a screening examination in cancer detection is still in doubt. Since early invasive or carcinoma in situ (such as can be detected by the cervical Pap smear) can seldom be recognized by this technique as it is now practiced, it is felt by many that this method should not be used as a screening technique. A better screening technique would be the examination of breasts by trained physicians. Even though at the present time, the technique of mammography can pick up three of four carcinomas of the breast per thousand, these are not carcinomas in situ or early invasive carcinomas, but are well-established carcinomas which should be just as easily palpated by the physician.

There can be no question that mammography is an aid to the physician and patient alike as an adjunct to the otherwise good examination. At present it should not be used as a diagnostic tool for those not already trained and skilled in breast examination. The error of diagnosis is still too great for it to be relied on blindly.

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Approved by the Professional Education Committee, Georgia Division ACS.

**March 3, 1966—"A Short Course in Proctosigmoidoscopy" sponsored by the Department of Surgery, Emory University School of Medicine in conjunction with the American Cancer Society, Grady Hospital Auditorium, Atlanta.**



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## CLINICAL AND LABORATORY EVALUATION OF MITRAL REGURGITATION

William J. Rawls, M.D., *Decatur*

**M**ITRAL REGURGITATION or insufficiency is a moderately common condition. At the present time, quantitation of the regurgitation is difficult, but a reasonably accurate appraisal is possible using the clinical and laboratory information currently available. Clinical appraisal is adequate in most cases but, in the patient who is being considered for surgical correction or replacement of the mitral valve, cardiac catheterization with angiography is desirable.

### Etiologies

Although the most common etiology of mitral regurgitation is rheumatic inflammation, it may also be due to bacterial endocarditis, myocardial infarction, trauma, congenital defects, or left ventricular enlargement from one of several causes. It is more frequent in females with a median age of 35-40. Fatigue, dyspnea and palpitation are frequent symptoms.

Because mitral regurgitation involves the ejection of part of the left ventricular contents into the left atrium, the left atrium and ventricle become dilated and hypertrophied. The left atrial enlargement cannot be detected on physical examination, but the left ventricular enlargement can be detected by the increased and sustained apex impulse.

### Auscultatory Findings

The auscultatory findings include a normal or decreased first sound, a normal second sound, and frequently an apical third sound. The systolic murmur of mitral regurgitation begins with the first sound and extends to, or slightly beyond, the second sound. It is loudest at the apex and may be crescendo, decrescendo, crescendo-decrescendo ("diamond-shaped"), or plateau. Transmission of the murmur is usually to the axilla, but may be to the base of the heart. There is frequently a diastolic murmur,

which occurs in mid-diastole and is a flow rumble (the apical diastolic murmur of acute rheumatic carditis is a mild-diastolic flow rumble associated with mitral regurgitation).

Left ventricular hypertrophy is the most consistent electrocardiographic finding. P mitrale may or may not be present, but atrial fibrillation often occurs in the advanced stages of mitral regurgitation. Cardiac x-rays and fluoroscopy confirm the presence of left atrial and left ventricular enlargement. Calcification of the mitral valve is frequent. The lungs have a normal appearance unless there is significant mitral stenosis or left ventricular failure.

### Cardiac Catheterization

Cardiac catheterization is most helpful when there is associated mitral stenosis. Analysis of the left ventricular and either the wedged pulmonary artery ("PC") or left atrial pressure curves is helpful in differentiating regurgitation from stenosis. Standard dye curves with either Evans blue or Cardio-Green can be used in mathematical manipulations to give reasonable estimates of the mitral regurgitation.

Probably the most useful measurement of mitral regurgitation is left ventricular angiography. This can be done during left heart catheterization by recording on rapid-sequence x-rays or cineangiograms the injection of contrast material into the left ventricle. The technique is semi-quantitative (left atrial and aortic densities are compared during maximum concentration of the contrast material and graded on a 0 to 4+ scale) but allows for the detection of small quantities of regurgitation and at the same time gives some visual indication of the type of regurgitation.

345 West Ponce de Leon Avenue

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

## CALL FOR SCIENTIFIC EXHIBITS

112TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Columbus, Georgia, May 8-10, 1966

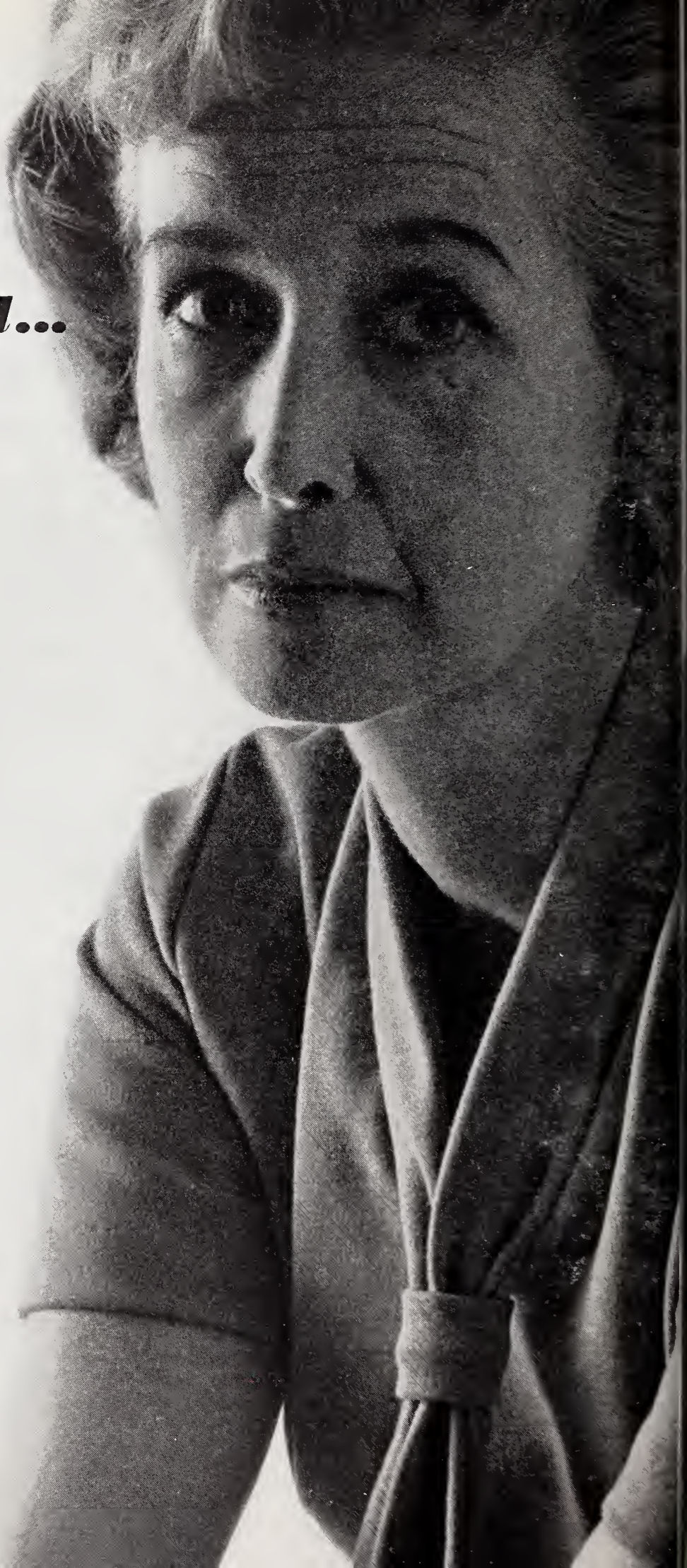
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John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee

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## HOSPITAL HELD LIABLE

John L. Moore, Jr., *Atlanta*

**O**N SEPTEMBER 28, 1965, the Supreme Court of Illinois entered a decision pushing the liability of hospitals beyond any previous case holding known to the writer. The decision is of obvious importance and concern to hospitals. It will also concern physicians.

### The Facts

The 18-year-old plaintiff had his leg broken while playing in a college football game. He was taken to the emergency room of a hospital where a medical doctor, serving on emergency call that day at the hospital, treated him. The physician, with the assistance of hospital personnel, applied traction and placed the leg in a plaster cast. A heat cradle was applied to dry the cast. Not long after the application of the cast, the plaintiff was in great pain and his toes became swollen and dark in color. The toes protruded from the cast so that they could be seen. The same physician, a day later, notched the cast around the toes. Two days later he cut the cast approximately three inches from the foot. On the third day he split the sides of the cast with a Stryker saw and in the course of cutting the cast, cut the plaintiff's leg on both sides. There was a stench in the room which one witness said was the worst he had smelled since World War II.

The plaintiff was transferred to a hospital in St. Louis where efforts were made to save his leg but eventually it had to be amputated eight inches below the knee.

At the trial of the case against the hospital, it was held liable for \$150,000 by the jury but given credit for \$40,000 already paid by the attending physician.

The Supreme Court of Illinois affirmed the lower decision. It said that its affirmance could rest on two grounds. One of such grounds might be consistent with past cases. The other extends the frontiers of hospital liability considerably.

### Nurses' Liability

One theory which the court said would support the verdict against the hospital was that it failed to

have a sufficient number of trained nurses for bedside care of all patients at all times capable of recognizing the progressive gangrenous condition of the plaintiff's right leg and of bringing the same to the attention of the hospital administration and to the medical staff so that adequate consultation could have been secured and such condition rectified.

That portion of the theory of the plaintiff that the nurses failed to recognize the onset of gangrene is consistent with the holding of earlier cases in other states. Those cases state that the performance of routine services of hospital employees normally done by them not under the direct supervision of medical doctors can make the hospital liable.

However, it appears that the Illinois court found that the nurses also had a duty to bring the condition of the plaintiff's right leg to the attention of the hospital administration and to members of the medical staff who were not the attending physician so that they could require consultation to assist the attending physician.

### A Further Theory

The court also approved of a further theory of the plaintiff as one alternative basis for the decision of the jury in this case. That theory read as follows:

"Failed to require consultation with or examination by members of the hospital surgical staff skilled in such treatment; or to review the treatment rendered to the plaintiff and to require consultants to be called in as needed."

The court also said that skilled nurses should have recognized the danger signals of gangrene and should have known that the condition could become irreversible in a matter of hours. The court said:

"At that point it became the nurses' duty to inform the attending physician, and if he failed to act, to advise the hospital authorities so that appropriate action might be taken. As to consultation, there is no dispute that the hospital failed to review Dr. Alexander's work or require a consultation; the only issue is whether its failure to do so was negligence. On the evidence before it the jury could reasonably have found that it was."

Under the second of the plaintiff's theories and under a part of the first of the plaintiff's theories, it



appears that the Illinois Supreme Court requires hospitals to review the work of staff physicians and to require such staff physicians to have consultations with the nurses and the hospital administrator think that the physician may be negligent.

### Extends Frontiers

To say the least, this decision extends previous frontiers of hospital liability. Of course, a nurse surely will not be held liable for discovering all kinds of possible negligence of attending medical doctors. However, in cases of gangrene and other observable conditions, it is quite possible that a nurse in Illinois should now report directly to the administrator of the hospital if she does not feel that the attending physician is doing a good job. The defending hospital apparently argued all of the accepted rules of law that hospitals as corporations may not practice medicine and that the attending physician was an independent contractor. The Illinois Supreme Court, quoting a New York decision, said that hospitals now operated differently from older days because they now regularly employ on a salary basis a large staff of physicians, nurses, and interns, as well as administrative and manual workers. The New York court further said that hospitals now charge patients for medical care and treatment, collecting for such services.

If the New York and Illinois courts are right, and

it should be observed that they speak for the states in which our two largest cities are situated, radical changes may well now be expected in hospital administration. It is a little hard to see how hospitals and medical staff may protect against the holding in the case discussed. Should there be a required consultation in every surgical case? Should nurses be trained to make direct reports to the lay administrator of the hospital without prior discussion with the attending physician or only after notifying the attending physician? Can the medical staff of a hospital require the attending physician to invite consultation? Can the hospital administrator direct the attending physician to request consultation from other members of the medical staff? Must the hospital administrator require a second consultation should a nurse think that the consulting doctor has not improved the situation? Who pays for such consultations?

This writer honestly believes that the Illinois court has gone beyond any holding which might be expected from a Georgia court. However, the implications of the decision are disturbing.

Suite 1220  
C & S Bank Building

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*Prepared at the request of the Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to the Medical Association of Georgia.*

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*The case discussed is Darling v. Charleston Community Memorial Hospital (Sup.Ct.Ill. Docket No. 38790, Sept. 28, 1965).*

## AMA REAFFIRMS STAND ON "USUAL AND CUSTOMARY" FEES

With a weather eye trained on the July implementation date of the Social Security medicare program, the AMA House of Delegates has moved to reaffirm its support of the "usual and customary" fee concept as the basis for reimbursing physician participants in all government programs.

The need for this stated and vocal reaffirmation of policy was triggered in part by the so-called "prevailing fee" program developed by the National Association of Blue Shield Plans last fall.

### Filing of Charges

Under the prevailing fee concept, participating physicians would be paid their usual and customary fee only if they first filed with the Plan a schedule of charges for all procedures and provided that these charges did not exceed the fee of 90% of the remaining physicians in the community.

The prevailing fee concept was one of the most controversial issues before the AMA House of Delegates at its December, 1965 meeting.

Aside from the controversy which this concept generated in its own behalf, there was much concern among the Delegates that acceptance of the prevailing fee mechanism would invite misinterpretation on the part of medicare administrators and other HEW officials in Washington. Following the discussions of these two issues—"prevailing fee" and "usual and customary"—it was clear that many of the Delegates were fearful that the regulations to be adopted for the administration of the medicare program might be materially influenced away from the usual and customary concept if the prevailing fee concept had been adopted *carte blanc*.

### To Take Note

Following many hours of debate in Reference Committee and on the floor, the House voted to take note of the prevailing fee program as one of the methods of compensation but only in those regions where this plan had been approved by the local or state medical association.





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1. Weese, H.: Personal Communication, Sept. 25, 1964. 2. Glynn, R.: Obst. & Gynec. 20:369, 1962.

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## THE ABUSE OF DRUGS

Kenneth Jones, M.D., *Augusta*

MAN'S TENDENCY to abuse drugs that alter his thinking, feeling or behavior is as old as history. Alcohol is an example of this. Man has available to him today an ever increasing variety of drugs that "effect the mind"—this has been especially true since the "era of the tranquilizer" began in the early 1950's. It would seem desirable for the physician to make every reasonable effort to try to limit the possibility of patients abusing drugs such as narcotics, sedatives, stimulants, tranquilizers, etc., that have been demonstrated to have addicting properties. A very familiar sight today is the patient or family who produces a paper sack full of bottles from various drug stores, prescribed by various physicians, with the original prescription date going back several years and still being refilled.

### Fantastic Lengths

Quite often the patient will go to fantastic lengths to deny and obscure his use of drugs. The patient may also openly or secretly use alcohol to excess or may take a strong pious stand against alcohol while consuming his large quantities of medication. The patient will usually rationalize at length the use of drugs with various somatic explanations. They are usually extremely stubborn, proud individuals who

resent any attempt to approach them on a psychological level.

The drugs are used to help them maintain their facade of being calm, strong, competent, hard working, independent, "cool" or martyred individuals. Needless to say, the medications eventually become a serious problem that has to be dealt with before any help can be given the patient in terms of his basic personality difficulties.

### An Essential Place

Certainly the above mentioned types of drugs do have an important and essential place in our medical armamentarium. It is, however, extremely important for the physician to take a careful history in regards to drug intake from the patient and at times from the patient's family before prescribing medication, particularly the types mentioned above. Another reasonable precaution that appears to be all too frequently forgotten is that of writing such prescriptions for a specific number of refills. These too oftentimes forgotten maneuvers could reduce considerably the iatrogenic component of many patients' difficulties.

*1445 Harper Street*

*Prepared at the request of the Sub-Committee on Mental Health of the Medical Association of Georgia.*

## FOUNDATION FOR VISUALLY HANDICAPPED CHILDREN SEEKS THOSE WHO ARE UNAWARE OF SERVICES

The Foundation for Visually Handicapped Children, Atlanta, has experienced a sharp increase in the number of referrals received involving infants born with severe visual defects due to the recent widespread measles epidemic affecting expectant mothers in the first trimester of pregnancy.

### To Agency's Attention

However, based on information from the American Foundation for the Blind, the U. S. Children's Bureau, and others, it is believed there may be a large number of additional cases in Georgia, from this cause, which have not yet come to the agency's attention.

The Foundation's chief function is to provide free home counseling services to parents of blind or near blind children in Georgia, from infancy to age 16, with

related services offered to promote the optimum development of the individual blind child.

Early case finding is of utmost importance for maximum effectiveness of the agency's service, as soon as possible after diagnosis of the visual defect, when parents' need for support and guidance is most crucial. Your cooperation in meeting this problem is requested.

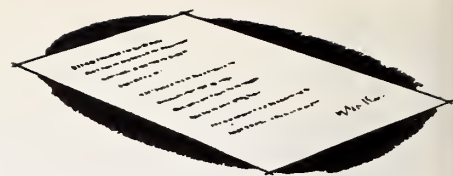
Referral can be made, via phone or letter, by physicians, or other interested, responsible persons, giving identifying information which will enable the agency to write parents, offering the free services.

Informed parents can, of course, make direct application.

*Communications should be addressed to:* Foundation for Visually Handicapped Children, 45-11th Street, N. E., Atlanta, Georgia 30309 (Telephone: 872-5315, area code 404).



# ABSTRACTS BY GEORGIA AUTHORS



**Ambrose, Samuel, M.D. and Justina H. Hill,** 1938 Peachtree Road, N.E., Atlanta 9, Georgia, "Colony Counts and Chronic Pyelonephritis," *J. Urol.* 94:15-19(July)65

The purpose of this study was to test validity of the concept that a pre-determined bacterial colony count level could be used as a criterion of significant urinary tract infection. The design of this study was to determine the number of viable micro-organisms in the bladder urine of patients with known significant urinary tract infection—chronic pyelonephritis.

The subjects of this investigation were 85 patients with the clinical diagnosis of chronic pyelonephritis, suggested by history and/or urinalysis (including culture from microflora) and corroborated by pyelographic changes and/or pathological study of the kidneys. No cultures were obtained if there was a history of antibacterial treatment within two weeks of the time of examination. Many of the patients had been untreated for their urinary tract infection. All of the subjects were considered to have persistent renal disease consistent with the clinical course of chronic pyelonephritis. The collection of specimens was carefully controlled in an effort to eliminate, as far as possible, contamination from the lower urinary tract, "build-up" of count levels by prolonged retention of the urine in the bladder or delayed transportation of the specimen from the patient to the laboratory for definitive cultural studies. Multiple plates were made from serial dilutions of the urine specimens and counting was restricted when possible to those plates revealing not less or more than 50 colonies per plate. The mean was taken of these counts and the number of colonies per milliliter of urine was calculated. Additional cultures upon appropriate media were made for identification and isolation of fastidious organisms. Duplicate smears were also made of urinary sediment for Gram-staining and examination for micro-organisms.

The results in a series of 146 urine specimens from 85 patients with chronic pyelonephritis were 1) no growth in 35%, 2) less than 10,000 colonies per cubic centimeter in 30.0% for a total of 65% and 3) only 30.1% with counts of 100,000 colonies per cubic centimeter or over.

Stained smears of urine sediments, with rare exception, revealed bacteria if the colony count was 10,000 or more. More than one bacterial genus was found in 47% of the specimens. *Escherichia coli* was the most common organism isolated, occurring in 45% of the patients.

The authors readily admit that 100,000 colonies per cubic centimeter of urine represents a significant urinary tract infection. However, they emphasized that counts of less than this order are not conversely insignificant but are

frequently associated with pyelonephritis. These studies suggest that the majority of patients with asymptomatic chronic pyelonephritis will be missed if  $10^5$  micro-organisms/cc. of urine is used as a standard index of infection. The importance of careful microscopic examination of the fresh and stained urinary sediment of a fresh and carefully collected urine specimen is discussed.

**Rosenthal, Sanford I.; Holde Puchtler, M.D.; and Faye Sweat, H.T., ASCP, Medical College of Georgia, Augusta, Georgia, "Paper Chromatography of Dyes,"** *Arch. Path.* 80:190-196(August)65

A method for paper chromatography of dyes was developed which employs only equipment readily available in a histology laboratory and does not require special training. Because of its technical simplicity this method has worked well in the hands of different users.

A beaker of 50 ml. capacity was placed in a rectangular staining dish and developing solution poured into the beaker and on the bottom of the staining dish. Whatman No. 1 filter paper was cut into a semicircle with stem. Dye solution was pipetted onto the junction of stem and semicircle and the stem immersed in the developing solution. The staining dish was then closed to minimize evaporation. When the developing solution reached the periphery of the semicircle the chromatogram was transferred to an empty beaker and permitted to dry.

Colored impurities could be demonstrated in 33 of the 45 dyes tested. However, at least part of these contaminants were apparently by-products inherent in the manufacturing process.

Application of this procedure to problems of histological technic showed that variations in the by-products of dyes can cause misleading alterations of staining patterns.

This investigation was supported by USPHS Research Grant No. GM 07303 from the National Institute of General Medical Sciences and Medical College of Georgia Professional Research Fund grants No. 05-5216 and 05-5234.

**Sweat, Faye, H.T., and Holde Puchtler, M.D., Eugene Talmadge Memorial Hospital, Augusta, Georgia 30902, "Demonstration of Amyloid with Direct Cotton Dyes,"** *Arch. Path.* 80:613-620(Dec)65

On the basis of histochemical investigations of the binding of direct cotton dyes by amyloid, a staining method was developed to color amyloid selectively without differentiation.

Experiments were carried out on human autopsy material fixed in buffered 10% formalin, unbuffered 10% formalin, Zenker-formol, absolute alcohol, or Carnoy's fluid and on museum specimens processed according to Kaiserling's procedure. Sections were placed

in buffered formalin overnight, treated with alkaline alcohol solution, and stained in a 1% solution of Sirius supra scarlet GG-CF or Sirius red F3BA in 0.5% aqueous NaCl solution for 1-1½ hours at 60°C. Sections were rinsed in buffer solution pH 9, washed in tap water, and counterstained with Mayer's acid hemalum.

Amyloid was colored pink (Sirius red F3BA) or orange (Sirius supra scarlet GG-CF); all other tissue structures except elastic fibers remained unstained. No fading was observed in sections stored for two and a half years. Because this method does not require differentiation, it gave uniform results in the hands of different users.

**Berry, J. Norman, M.D., 6363 Roswell Road, N.E., Atlanta, Georgia 30328, "Benign Intracranial and Neck Bruits in an Adult,"** *Ann. Int. Med.* 63:661-663(Oct)65

Although intracranial bruits of benign origin are common in infants and younger children, these bruits are nearly always of pathologic origin when found in adults. The present report is that of a 36-year-old housewife who manifested spontaneous systolic to continuous neck murmurs and continuous intracranial (globe) murmurs over a period of three years without clinical, laboratory, or x-ray evidence of serious vascular or intracranial pathology. Bilateral carotid and intracranial arteriograms were normal. Similar murmurs were heard for a time in one of her children. It is speculated that these bruits were of benign origin, perhaps related to a dynamic circulation in an individual with elastic blood vessels. The possibility that such murmurs may have a familial predisposition is discussed.

**Puebla, Ruben A., M.D.; Arturo Zarate, M.D.; and Robert B. Greenblatt, M.D., Medical College of Georgia, Augusta, Georgia, "Ethinodiol Diacetate: Clinical Experience with a New Synthetic Oral Progestin,"** *Fertility and Sterility* 16:805-812(Nov-Dec)65

Ethinodiol diacetate was administered to 178 women for contraception and a variety of gynecologic disorders. One or 2 mg. doses of the progestin combined with 0.1 mg. of mestranol proved an effective contraceptive agent. The drug was also effective in the management of essential dysmenorrhea and premenstrual tension. Dysfunctional uterine bleeding was arrested readily within 24-72 hrs. with the estrogen-progestin compound. In the delay-menses test 1 mg. of the progestin combined with 0.1 mg. of mestranol effectively delayed onset of menses in 64% of trials, and 2 mg. with 0.1 mg. of mestranol in 97% of trials. Ethinodiol diacetate is an excellent progestational agent, readily converting a follicular endometrium into a secretory one. No untoward effects were noted.



# PHARMACEUTICAL FIRMS SUPPORT PROGRAM ON RESEARCH BY DEPARTMENT OF MEDICINE, EMORY UNIVERSITY SCHOOL OF MEDICINE

Nine pharmaceutical firms have contributed to a fund for the support of a one-day program at which members of the house staff and fellows in Emory University School of Medicine's department of medicine will present reports on their research. The reports will be made April 1 in the auditorium of Grady Memorial Hospital.

The member of the house staff and the fellow who present the best papers in their respective categories will receive an all-expense paid trip to the annual meeting of the American Federation for Clinical Research to be held in May in Atlantic City, N. J.

The program is being conducted by Emory's department of medicine.

Dr. William M. Marine, assistant professor of preventive medicine and community health, is chairman of the faculty committee which approves the research projects on which reports will be given. Dr. J. Willis Hurst, chairman of Emory's department of medicine, started the program some years ago and is ex-officio member of the committee. Other members are Drs. John T. Galambos, Robert F. Kibler, Robert C. Schlant and Elbert P. Tuttle.

Research projects on which reports will be made were conducted at Grady Memorial Hospital.

The sponsoring pharmaceutical firms are: Ciba; Eli Lilly; Hoffmann-La Roche; Merck, Sharp and Dohme; Parke Davis; Pfizer; Squibb; Upjohn, and Wyeth.

## 1966 CALENDAR OF MEETINGS

### State

Postgraduate Courses sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.

January 12-March 30—Psychosomatic Medicine follow-up course (12 weekly evening sessions).

February 22-23—Obstetrics and Gynecology

March 10—The Adolescent Girl

March 24-25—Trauma

December 7-May 12—Georgia Circuit Courses (six sessions, one day each month at six centers in Georgia).

February 21-25 (to be repeated April 18-22)—"A Short Course in the Administration of Nursing Service in Nursing Homes," sponsored by the School of Nursing, Medical College of Georgia at the Fulton County Department of Health, 99 Butler St., S.E., Atlanta.

March 3—"A Short Course in Proctosigmoidoscopy" sponsored by the Department of Surgery, Emory University School of Medicine, in conjunction with the American Cancer Society, Grady Hospital Auditorium, Atlanta.

March 10—One Day Symposium, "Endocrinology and the Adolescent Girl," sponsored by the Richmond County Medical Society and the Georgia Academy of General Practice, Augusta Town House Hotel, Augusta.

March 15-19—Postgraduate Seminar in "Fundamentals of Otolaryngologic Allergy," sponsored by the University of Tennessee College of Medicine, Memphis, Tenn.

March 16-18—A Symposium on "Clinical Aspects of Renal-Endocrine Interactions," presented by the Department of Medicine, Emory University School of Medicine, Grady Hospital Auditorium, Atlanta, Ga.

April 4-8—39th Annual Spring Congress in Ophthalmology and Otolaryngology sponsored by The Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.

April 12—1966 Paramedical Personnel Symposia to be held simultaneously in the following ten Georgia cities: Albany, Atlanta, Augusta, Columbus, Dublin, Gainesville, Macon, Rome, Savannah, and Waycross. The Symposia are co-sponsored by the Georgia Heart Association, Georgia State League for Nursing, Georgia Society of Medical Technologists, Georgia Dietetic Association, and the Georgia State Nurses Association.

April 11-16—"Workshop in Radioisotope Scanning," Emory University School of Medicine, Atlanta.

April 13-16—19th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Va.

April 14-16—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, Grand Bahama Hotel, Grand Bahama Island.

May 5-7—Ninth Biennial Cardiovascular Seminar, "Newer Methods in Ischemic Heart Disease," presented by the Section of Cardiology, University of Miami School of Medicine and the Heart Association of Greater Miami, Carillon Hotel, Miami Beach, Fla.

May 8-10—112th Annual Session of the Medical Association of Georgia, Columbus, Ga.

### Regional

September 15, 1965-June 15, 1966—A nine month tutorial program in Cardiology offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

February 28-March 3—Southeastern Surgical Congress, Mariott Motor Hotel, Atlanta, Ga.

February 28-March 4—Seminar in Obstetrics and Gynecology. Cruise to Nassau and Freeport in the Bahamas, S.S. *Ariadne*. Sailing from Ft. Lauderdale, Fla. Presented by the Dept. of Obstetrics and Gynecology, College of Medicine, University of Florida. Approved by Florida State Board of Health, Florida Medical Association, and Florida Academy of General Practice.

March 7-10—New Orleans Graduate Medical Assembly (29th Annual), The Roosevelt Hotel, New Orleans, La.

March 21-23—Dallas Southern Clinical Society, Statler-Hilton Hotel, Dallas, Tex.

### National

February 27-March 4—International Anesthesia Research Society (40th Congress), Americana Hotel, Bal Harbour, Fla.

March 23-25—American Surgical Association, Boca Raton, Hotel, Boca Raton, Fla.

May 23-25—Annual Meeting of the American Thoracic Society, Medical Section of the National Tuberculosis Association, San Francisco, Calif.

June 26-30—American Medical Association Annual Convention, Chicago.



# THE ASSOCIATION



## PERSONALS

### Second District

Members of the staff of Archbold Memorial Hospital, Thomasville, were recently honored at a dinner party given by members of the Board of Trustees of the hospital. A five gallon donor pin was presented to **Warren Taylor**, the first Chairman of the Thomas County Bloodmobile program. Dr. Taylor served for three years as Chairman of the South Atlantic Regional Blood program. Dr. and Mrs. **George Dillinger** were presented a silver tray for 20 years' service on the hospital staff. The Dillingers are leaving Thomasville for Dublin, where Dr. Dillinger will join the VA Hospital staff.

Two Bainbridge physicians, **Charles Bellville**, and **E. Ashby Woods** recently were among 100 area physicians attending the Latin-North American Medical Seminar in Merida, Yucatan, Mexico.

### Fifth District

Two Atlanta doctors have been elected to posts in the Southern Medical Association. **H. Harland Stone** has been named Vice-Chairman of the association's Section on Surgery, and **Sidney Olansky** has been elected Secretary of the Section on Dermatology.

The Medical Staff of DeKalb General Hospital has elected officers to serve during the hospital's current fiscal year.

**Fincher C. Powell** was elected Chief of Staff. The Vice-Chief is **Earnest C. Atkins** and the Secretary is **Robert I. Gibbs**.

Officers have also been named for the departments of the staff. They are:

ANESTHESIOLOGY—Chief, **George P. Sessions**.

GENERAL PRACTICE—Chief, **John Schreeder**; Vice-Chief, **Donald Rairigh**; Secretary, **Leon Carter**; additional representative on the Executive Committee, **L. L. Freeman**.

MEDICINE—Chief, **Chester Morse**; Vice-Chief, **Virginia Tuggle**; Secretary, **Ben Okel**.

OBSTETRICS and GYNECOLOGY—Chief, **Byron Dunn**; Vice-Chief, **Betty Ann Brooks**; Secretary, **John Walker**.

PATHOLOGY—Chief, **Frank Matthews**.

PEDIATRICS—Chief, **Gerson Aronovitz**.

RADIOLOGY—Chief, **Frank Morgan**.

SURGERY—Chief, **A. H. Fregosi**; Vice-Chief, **S. A. Wills**; Secretary, **E. H. McDowell, Jr.**

**James T. King**, Atlanta, has recently been elected President of the International Association of Secretaries of Ophthalmological and Otolaryngological Societies, and to the Medical Advisory Board of the Executive Audial Rehabilitation Society.

**Sidney Olansky**, Atlanta, has been named Chairman of the Fulton County Medical Society's Committee on

Venereal Disease. Appointed to serve with him are **John T. Yauger**, **Frank L. Wilson, Jr.**, **J. Watts Lipscomb**, and **T. E. Billings**.

**Robert M. Fine**, Atlanta, participated in a Symposium on Nephro-Cutaneous Disease at the American Academy of Dermatology in Chicago, December 3-9, 1965.

**Floyd R. Sanders, Jr.**, Decatur, was elected to the DeKalb County Hospital Authority at its December meeting to fill the unexpired term of the late **J. R. McCain**.

### Seventh District

New officers of the medical staff of John L. Hutcheson Memorial Tri-County Hospital, Lafayette, for 1966 are **Edward G. Johnson**, Chattanooga, Chief of Staff; **Leroy Sherrill**, Rossville, Vice-Chief of Staff; and **Garland E. Kinard**, Fort Oglethorpe, Secretary.

### Ninth District

Doctors throughout northeast Georgia recently attended a heart symposium at Lake Louise Conference Grounds near Toccoa. Taking part were **Bob Ellison**, Calhoun Whitham, William Engler, James C. Dudley, Scott Donovan, Sam Hay, P. B. Cleveland, J. W. Williams, Jr., Olin Garrison, and Terrell Tanner.

### Tenth District

**J. W. Williams, Jr.**, a Lavonia physician, has been named Chief of Staff at Hart County Hospital.

**Randall Couch**, who recently began the practice of medicine in Lavonia, was named Secretary-Treasurer. **Morris Dalton** of Hartwell was chosen Vice-Chairman.

## COUNTY MEDICAL SOCIETIES

C. E. Powell, M.D., of Swainesboro, is the newly elected President of **Emanuel County Medical Society**. He succeeds H. R. Frost, M.D., also of Swainesboro. Other officers elected are Vice-President, Robert Moye, M.D. Secretary-Treasurer, Ed Strickland, M.D.; MAG Delegate, Robert Moye; and Alternate Delegate, Bill Gray M.D.

**The Georgia Medical Society**, Savannah, at its annual meeting elected Peter L. Scardino, M.D., as President-Elect. Dr. Scardino will take office in 1967, when he will succeed Jules Victor, M.D., the newly elected President. Dr. Victor succeeds Robert B. Gottschalk M.D.

Elected to the post of Vice-President was Thomas A. McGoldrick, Jr., M.D. Re-elected were Jeff J. Hollo man, M.D., Secretary, and Joseph J. Doolan, Jr., M.D. Treasurer. Martha Gordy, M.D., was elected Historian. Hollis Pucket, M.D., a member of the Board of Stewards, and Dr. Gottschalk, a member of the Board of Trustees.



Elected as delegates to the Medical Association of Georgia, with terms expiring in 1967, were Lee Howard, Jr., M.D., with Alton F. Williams, M.D., as Alternate, and Irving Victor, M.D., with William G. Sutlive, M.D., as Alternate.

Robert Ennis, M.D., was elected as a member of the

endowment fund from the society at large.

Joyce Mixon, M.D. of Valdosta was elected President of the **South Georgia Medical Society** at the last quarterly meeting held in December. Other officers are William N. Gee, M.D., Vice-President; and Richard Nutt, M.D., Secretary-Treasurer.

## THOUGHTS ABOUT ANTIBIOTIC COMBINATIONS

In looking at combinations of antibiotics we have seen the contributions made by following scientific curiosity. We have seen how this curiosity can be directed so that it leads to applications in disease. We have seen that these applications have to be measured by what they will do for man. We have seen that some pass the test and are widely used, whereas others fail

to pass or are poorly measured. We have seen that the combined will of doctors can enforce the results of the measurement. We have seen that such leadership is desired by the majority of pharmaceutical manufacturers and that when it is given, they will respond to it.—Harry F. Dowling, M.D., in *Transactions & Studies of the College of Physicians of Philadelphia*, July 1963.

## FULLY COMPREHENSIVE REHABILITATION CENTER TO BE ESTABLISHED AT WARM SPRINGS

To help an individual develop a new work skill while he is receiving medical treatment is the idea that has brought a comprehensive rehabilitation center to Georgia.

Doctors, therapists, teachers, vocational counselors and other professional people who deal with disabled people have recognized the need for such a center for many years. The Georgia Warm Springs Foundation, which operates one of the world's foremost medical rehabilitation centers, and the Georgia Division of Vocational Rehabilitation, a leader in the field of vocational rehabilitation, have now formulated a plan to establish a fully comprehensive rehabilitation center at Warm Springs.

### Outstanding Individuals

This brings together two of the nation's outstanding individuals in the field of rehabilitation, Dr. Robert L. Bennett, Executive Director of the Georgia Warm Springs Foundation, an authority and leader among physicians in the field of physical medicine and rehabilitation, and Dr. A. P. Jarrell, Director of the Georgia Division of Vocational Rehabilitation, a recognized national leader in the field of vocational rehabilitation.

This center will offer a wide variety of services that will enable many disabled people to receive medical treatment and many other services such as vocational training, work evaluation and job try-out at the same time. Thus, many can reduce the time required to return to work following serious illnesses and injuries, and others who might never be able to return to work without these services will now become working citizens.

The State Board of Education, with grants of Hill-Burton Hospital Construction Funds, is erecting buildings on land deeded to the State of Georgia by the Georgia Warm Springs Foundation that will make possible these expanded services. The buildings are being designed to permit the convenient use of wheelchairs in all rooms and spaces. Various centers throughout the nation have been studied to insure that the best known

architecture and design for this type of facility are included.

The present design of new buildings includes housing for 133 people, areas for vocational training where skills specially adaptive to the disabled will be taught, work evaluation where many will be assisted in determining the most appropriate field of work to follow, and a rehabilitation adjustment workshop where work experience will be provided. Recreation and dining facilities are included. This, together with the present capacity at the Georgia Warm Springs Foundation, will bring the total available beds for disabled individuals at Warm Springs to approximately 250. Many people can be served without occupying beds at these facilities, making it possible to provide services to a total of about 450 people on any given day.

A large variety of services will be available as a result of this expanded program. They will include: medical treatment and consultation; orthopedic surgery; physical therapy; occupational therapy; speech and hearing therapy; artificial appliances; braces; nursing; vocational counseling; psychological counseling and testing; social casework; vocational training; rehabilitation workshop therapy, and work experience.

### All Who Need Help

While all facilities at Warm Springs are designed to enable the seriously disabled to use them, it is anticipated that many people with less serious disabilities will take advantage of the facilities. This center will be open to all who can receive help from the services offered.

The expanded program has been made possible through a large number of agencies and individuals, including the Georgia Warm Springs Foundation, the Governor and the General Assembly, the State Board of Education, the State Department of Education, the Georgia Division of Vocational Rehabilitation, the Federal and Regional Offices of Vocational Rehabilitation, the Georgia Department of Public Health and the United States Public Health Service.



## SUMMARY OF RECENT MAG COUNCIL AND EXECUTIVE COMMITTEE ACTIONS

(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal).

### Executive Committee of Council/December 11, 1965

**Reading of Minutes**—Mr. Krueger was asked to defer the reading of the minutes until the Council meeting. It had been brought to the attention of the Executive Secretary that there was an omission in attendance at the October 24, 1965, meeting and Mr. Krueger was instructed to add John S. Atwater, Atlanta, to those attending that meeting.

**Treasurer's Report**—Deferred until the Council meeting.

**Appointments**—The following were appointed by Executive Committee:

(a) **Talmadge Hospital Liaison Committee:** RCMS—Charles W. Hock, Augusta (1968), W. A. Wilkes, Augusta (1966); MCG—Harry B. O'Rear, Augusta (1967), Rufus Payne, Augusta (1968); 1st—J. Miller Byne, Jr., Waynesboro (1968); 2nd—H. G. Davis, Jr., Sylvester (1967); 3rd—Harry H. Boyter, Columbus (1968); 5th—Lamar B. Peacock, Atlanta (1968); 6th—Milford B. Hatcher, Macon (1967); 8th—Robert A. Pumpelly, Jesup (1967); 9th—Paul T. Scoggins, Commerce (1967).

(b) **Interprofessional Council:** William A. Wood, Atlanta (1968).

### Title XVIII, PART B, P.L. 89-97—

(a) **MAG Proposal as Carrier:** Dr. Mauldin reported that the criteria for qualification as carrier had been received and that the application from MAG had been prepared and would be mailed by December 15, to the Social Security Administration in Baltimore. Received for information.

(b) **Blue Shield "Prevailing Fee Program" Meeting:** Dr. Jennings stated that this meeting held in Macon, December 9, 1965, was a very interesting one. The prevailing fee program is in operation in several states. In essence the concept is that the Blue Shield would ask the individual physicians to submit to the Blue Shield for confidential use, a list of their usual and customary charges for the procedures they normally perform. This would then be submitted to computer analysis and a profile of the physicians' charges in the community would be made. According to that information the Blue Shield would then try to sell a contract to industry and business in which the participating physician would accept the Blue Shield payment and that he would submit his usual and customary charge for services rendered. It was believed this plan would pay in full at least 90% of the physicians and 90% of the claims.

Mr. Moffett read the action of the AMA House of Delegates on prevailing fees as follows: "That the concept of the prevailing fees program of the National Association of Blue Shield Plans be noted as one of the methods of compensation in those regions where the prevailing fee program is approved by the local or state medical society."

After discussion on the prevailing fee program on motion (Mauldin-Brown) the Executive Committee voted not to approve the prevailing fee concept and to refer it to the Insurance and Economics Board for further investigation.

**MAG Medical Placement Service**—Dr. Mauldin discussed the operation of the Medical Placement Service and on motion duly made and seconded it was voted to refer this matter to Council.

**Headquarters Office Report**—Mr. Krueger reported on the following items:

(a) **Office Equipment:** Collating Machine—On motion it was voted to recommend to Council the purchase of this equipment.

### NEW BUSINESS—

(a) **Report on Governmental Programs Meeting:** Dr. Alexander met with Drs. Venable, Godwin and Cowart this past week concerning the various governmental programs that might be available. Dr. Venable discussed the Heart, Cancer and Stroke programs; Dr. Godwin discussed the Assistance to Medical Librarians and other related activities, the DeBakey bill, and recruitment programs for paramedical personnel; Dr. Cowart also reported on the Community Health Services Committee meeting. On motion duly made and seconded, it was voted to ask the President to call a coordinating committee meeting, after he discusses the matter with the Dean of the Emory University School of Medicine, if indicated.

(b) **Georgia Register of the Blind Request:** Dr. Mauldin read a letter from the *Georgia Register of the Blind* in which

they asked for certain information from our members regarding (1) blind persons not known to public agencies; and (2) pre-school blind children. After discussing the best way to reach the membership, it was voted to endorse the project and to ask the *Georgia Register of the Blind* to submit an article for publication in the *JMAG*.

(c) **AMA Air Pollution Conference, Los Angeles, March 2-4, 1966:** It was voted not to send a representative to this conference.

### Council Meeting/December 11-12, 1965

**Reading of Minutes**—Mr. Krueger reviewed the minutes of the Executive Committee meetings of September 25, October 24 and November 21, 1965; and the Council meeting September 25-26, 1965. These were approved as read but attention was called to the resolution submitted by the Richmond County Medical Society concerning the naming of the new research and education building at the MCG. Dr. Pinson stated that the action requested by Council had not been carried out and that was to refer the resolution to the Board of Regents. This action had not been carried out by the Executive Committee because it had been learned that the building had already been named. However, after clarifying discussion, on motion (Pinson-Bohler), it was voted that the Richmond County Medical Society resolution be forwarded to the Board of Regents. Drs. Pinson and Bishop and Mr. Krueger were asked to draft this resolution.

**Treasurer's Report**—Dr. Atwater presented the Treasurer's report. Council voted to accept the report as presented.

**Title XVIII, Part B, P.L. 89-97 MAG Proposal as Carrier**—Dr. Mauldin presented the information that MAG's application to seek appointment as carrier under Title XVIII, Part B, P.L. 89-97 had been prepared and would be mailed by December 15. Council received this for information and will await the action taken on the application by the Social Security Administration.

**MAG Councilor Redistricting**—Mr. John Moore, MAG Attorney, gave a report on the method of the redistricting of councilor districts for Council consideration. It was recommended that the fairest procedure is for Councilors and Vice Councilors presently representing Districts whose geographical boundaries have been changed at all, resign effective at the Annual Session next spring. This would affect the First, Second, Third, Fourth (probably no Councilor), Fifth (no Councilor), Sixth, Eighth, Ninth and Tenth Districts. Accordingly, the nine named Districts, except for the Fifth, and depending on the Newton-Rockdale action, the Fourth, should organize and make nominations to the Association prior to the Annual Session (by April 15, 1966) in accordance with the Constitution and By-Laws.

It will not be necessary for renominations to be made by Georgia Medical Society, Muscogee Medical Society, or for the Councilor and Vice Councilor of the positions presently held by Drs. Bishop and Harrison of the Fulton County Medical Society. However, the terms of Drs. Jones and Jolley expire in the Fulton County Medical Society, and the terms of the present Councilors and Vice Councilors of the Bibb County Medical Society and Richmond County Medical Society expire at the next Annual Session under previous staggering of Councilor terms. At the 1966 Annual Session, the Fulton County Medical Society will need to elect one Councilor and Vice Councilor for a term ending at the 1967 Annual Session, and one Councilor and Vice Councilor whose terms end at the 1969 Annual Session.

On motion (Bishop-Bohler) Council voted to accept the above recommended method of councilor redistricting in principle and refer the matter to the Executive Committee for implementation.

**Social Security Law Application to Physicians**—Mr. Moore gave detailed information on certain questions asked by members.

**1966 Proposed Budget**—Dr. Eldridge reported in detail the proposed budget made by the Finance Committee and approved by the Executive Committee. On motion duly made and seconded the recommended budget for 1966 was adopted.

**AMA Delegates Report**—Dr. Chambers, Chairman of the MAG Delegation, reported on the last two sessions of the AMA House of Delegates, emphasizing certain actions taken.

**Ad Hoc Community Health Services Committee Report**—



Mr. Kruger presented a report of the MAG Ad Hoc Committee on Community Health Services for Chairman Charles Cowart based on a meeting of this Committee held December 5, 1965. In summary, Mr. Krueger stated that the Committee proposed: (1) possible proposed formation of a statewide Area Hospital and Health Planning Council; (2) stimulation of new Areawide Hospital and Health Planning Councils in medical complex regions over the state; and (3) study and propose activity in the field of paramedical recruitment to meet the needs in Georgia. This report was received for information.

*Areawide Hospital and Health Planning Committee Meeting Report*—Chairman J. L. Mulherin, of the Areawide Hospital and Health Planning Committee, reported that his Committee was sponsoring a January 16, 1966, Macon meeting for representatives of all county medical societies in an effort to further inform physicians about the activity, stimulation, and responsibilities of doctors on Areawide Hospital and Health Planning Councils. This report was received for information.

*Paramedical Education Committee Report*—Mr. Krueger presented a report of the Committee on Paramedical Education for Chairman John Godwin. This report reviewed the activity of the Committee to date and President Alexander stated that Dr. Godwin, of the Paramedical Education Committee, and Dr. Cowart, of the Community Health Services Committee, were meeting together to correlate their activity on the problem of paramedical education and recruitment. This report was received for information.

*Governmental Programs Review Committee Report*—President Alexander reported on a meeting which he attended with Dr. John Venable, Director, State Department of Health; Charles Cowart, Chairman of the MAG Community Health Services Committee; and John Godwin, Chairman of the MAG Paramedical Education Committee. Dr. Alexander stated that the main recommendation of this Committee was to convene a small group of interested persons to discuss the implications of the Heart, Cancer and Stroke Law (DeBakey) and to consider other Governmental Programs now available. This report was received for information.

*Mental Health Committee Report*—Mr. Krueger reported on the activity of the MAG Mental Health Committee for Chairman W. D. Stribling. He informed the Council, that the Mental Health Committee was sponsoring a meeting in March, 1966, for representatives of county medical societies on the subject of "Community Mental Health Centers." The program for this proposed meeting was discussed as an activity of the Mental Health Committee. This report was received for information.

*Public Service Board Report*—Mr. Krueger reported on the activities of the MAG Public Service Board for Chairman Robert Wells. He reviewed the proposed program for the MAG Annual "County Medical Society Leadership Conference," annually held in February for the representatives of all MAG County Medical Societies as sponsored by the Public Service Board. This report was received for information.

*MAG Maternal and Infant Welfare Committee Report*—Mr. Krueger presented a specific recommendation from the MAG Maternal and Infant Welfare Committee as transmitted to the Council by Dr. Morris E. Brackett, Secretary of the Committee. The following position was taken by the Committee on the subject of Phenylketonuria as follows:

"The Committee is in sympathy with the objectives of the Brinkley Bill which is the early detection of PKU in the prevention of the disease state and its sequelae. However, it feels strongly that legislation on such subject is unnecessary according to a recent ruling by the Attorney General.

"The laws under which the State Board of Health operates give ample authority for the prescribing and enforcing of rules and regulations concerning this and other subjects of similar nature. We are unofficially informed that the Director of the Georgia Department of Public Health can and will develop and issue rules and regulations concerning this subject.

"The Committee further feels that legislation in a field of new and incompletely explored areas of disease would be most disadvantageous in the light of future studies and might even prove hobbling to the efforts that the bill is intended to promote."

After discussion on motion (Jennings-Alexander), it was voted that the Council accept the report of the MAG Maternal and Infant Welfare Committee on PKU and that this be referred to the MAG Legislative Committee for use

in the 1966 session of the Georgia General Assembly.

*MAG Fee Schedule Negotiating Committee Report*—Dr. Henry Jennings, Chairman of the Association Fee Schedule Negotiating Committee, reported on the Committee action to date. He informed the Council of the responsibility of the Fee Schedule Negotiating Committee in any Government contracts made by MAG for its membership. Pursuant to this responsibility, Dr. Jennings presented data gained from his Committee for use in negotiating with the Office of Dependents' Medical Care pursuant to the Association contract to administrate the Dependents' Medical Care Act. Dr. Jennings requested endorsement and approval of the Council to conduct such a negotiation with his full committee, and on motion (Godwin-Jones), it was voted that the MAG Council give this Committee the full authority to negotiate with ODMC and that this be binding on MAG Council.

*MAG Insurance and Economics Board Report*—Dr. Henry Jennings, Chairman of the Association's Insurance and Economics Board, reported on the activity of the Board at their recent meeting. He stated they were working on and actively concerned with (1) inclusion of mental health coverage in insurance policies; (2) stimulation of the Life of Georgia-MAG Group Insurance Plan revision; (3) Radiology practice on billing by radiologists for professional fees; and (4) Blue Shield concept of "Prevailing Fees."

*Report of MAG Representative on Second National Conference on Cardiovascular Diseases*—Dr. Thomas Ross, Jr., of Macon, MAG representative to the National Conference on Cardiovascular Diseases, reported on a Second National Conference on this organization. After his report, on motion (Alexander-Collins), it was voted that this activity by Dr. Thomas Ross, Dr. J. W. Chambers and Dr. Henry Jennings as MAG representatives, be continued and that the terms of office of these three representatives be staggered for new appointments as recommended by Dr. Ross.

*Council Commendation Letters*—President Alexander stated that the Executive Committee of Council had recommended letters of commendation to be written to Dr. Edgar Woody, Jr., as Editor of the *Journal of the Medical Association of Georgia*; Mrs. Louie H. Griffin, Sr., as President of the Woman's Auxiliary to MAG; and Dr. Thomas Lumsden, as Chairman of the Association's Rural Health Committee. By general agreement, the Council approved the writing of such letters by the President to those persons concerned.

*Steiner Clinic Enlargement*—Dr. Lester Rumble, Atlanta, presented a request for approval by the Medical Association of Georgia of a plan to be submitted to HEW requesting a grant to enlarge the outpatient clinic for therapy of chronic obstructive pulmonary disease. This activity has been primarily previously supported by a grant through the medium of the Albert Steiner Memorial Foundation. Dr. Rumble went into detail on this matter, also submitting letters from the DeKalb County Medical Society and the Fulton County Medical Society on this subject. On motion (Jones-McDaniel), the Council voted to write such a letter of endorsement on this project for Dr. Rumble's use.

*State Board of Health Activities*—President Alexander reported on the liaison activity between the Medical Association of Georgia and the State Board of Health, and this report was received for information.

*MAG Headquarters Office Report*—Executive Secretary Krueger presented a résumé of the activity of the MAG Headquarters Office Staff which was received for information. In addition to this presentation, he read a recommendation from the Executive Committee of Council in favor of purchasing a "collating machine" for use in the Headquarters Office. By general agreement, the Council approved the recommendation of the Executive Committee and authorized the purchase of this piece of equipment at approximately \$375.00 to be taken from the 1965 Contingent Fund.

*New Business*—Chairman Andrews then called for New Business and the following items were considered:

*MAG Medical Placement Service*—Secretary John Mauldin presented certain problems apparent in the operation of the Headquarters Office Medical Placement Service under the direction of the Special Activities Board. After due discussion, on motion (Eldridge-Collins), it was voted to continue the Placement Service as in the past.

*Georgia Society of Crippled Children Request*—Mr. Krueger reporting for Dr. T. A. Peterson presented a request of MAG endorsement for a proposal by the Georgia Society of Crippled Children grant from Government. After some discussion of this matter, it was referred to the Executive Committee of Council for disposition with notification to Dr.



## SUMMARY OF MINUTES / Continued

Peterson so that he might handle the matter with Executive Committee of Council.

*Interprofessional Council Resolution on Ownership of Pharmacies*—A resolution of the Interprofessional Council was presented to Council for consideration by Mr. Moffett. After due discussion of the proposed resolution, it was pointed out that there might be some conflict in the proposed resolution as it relates to the AMA Judicial Council action on this same matter. On motion (Bishop-Mauldin), it was

voted that the resolution of the Interprofessional Council on the Ownership of Pharmacies be referred to the MAG Medical Ethics Committee for recommendation back to the MAG Council.

*Cook-Berrien County Medical Society Request*—Eight District Councilor Frank Eldridge presented a request from the Cook-Berrien County Medical Society to become a part of and join the South Georgia Medical Society. After discussion on this matter, the MAG Council voted to approve the request of merging the Cook-Berrien County Medical Society into the South Georgia Medical Society.

## DRUG INFORMATION ASSOCIATION 1966 MEETING IN CHICAGO TO FEATURE ADVANCES IN INFORMATION PROCESSING

What new techniques have been developed for processing the enormous amount of information about drugs that pours from drug firms, universities, government agencies and medical organizations today?

The question is vitally important to all persons and organizations handling drug information. If communication of pertinent drug information lags seriously, significant data may be lost or its transmission delayed.

Description and discussion of new techniques will be aired in Chicago on June 25-26, at the 1966 meeting of the Drug Information Association. "Advances in Drug Information Processing" is the theme of the meeting.

The Drug Information Association is a recently-formed organization which held its first national meeting in October, 1965. Its membership consists of rep-

resentatives of the American Medical Association and other medical or para-medical groups, the Food and Drug Administration and other government agencies, pharmaceutical firms, and universities. Its purpose is "to further modern technology of communication in medical, pharmaceutical and allied fields."

The program will include 30-minute contributed papers, invited presentations, and some audience-participation discussions.

Abstracts of contributed papers are to be submitted before April 1 to the program chairman, Dr. O. F. Buchanan, Sterling-Winthrop Research Institute, Rensselaer, New York.

Registration for the meeting will cost \$15 for members of the Drug Information Association and \$20 for non-members.

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JOURNAL  
THE MEDICAL  
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*Georgia*

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# JOURNAL OF THE MEDICAL ASSOCIATION

# Georgia

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rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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# 112th Annual Session

## Official Call

**Extended to All Members of the  
Medical Association of Georgia**

**T**HE OFFICIAL CALL for the 112th Annual Session of the Medical Association of Georgia is hereby extended to all Association members. This meeting will be convened on May 8, 9, and 10 at the Municipal Auditorium, Columbus, Georgia. While certain Association Scientific Section meetings will of necessity be convened at other sites in Columbus on Sunday afternoon, May 8, all MAG General Business Sessions, House of Delegates meetings, and General Sessions on Socio-Economic and Scientific subjects will be convened at the Municipal Auditorium. Commercial exhibits and Scientific Exhibits will be displayed at the Municipal Auditorium just adjacent to the Auditorium meeting room. Social events and Related Meetings have been planned in conjunction with the Annual Session and many of the Georgia Specialty Societies will have their own business meetings, luncheons and dinners. The Woman's Auxiliary to the Medical Association of Georgia will convene their 41st Annual Convention during the MAG Annual Session at the Ralston Motor Hotel, Columbus.

### Registration

The MAG Official Registration Desk will be located at the entrance way of the Municipal Auditorium adjacent to the Exhibit Hall and Meeting Room in the Auditorium.

The Registration Desk will be open for member's registration and guest's registration on Sunday afternoon, May 8 from 1:00 P.M. to 6:00 P.M.; Monday, May 9 from 8:00 A.M. to 5:00 P.M.; and Tuesday, May 10 from 8:00 A.M. to 12:00 NOON.

MAG members and guests are requested to register on arrival in Columbus to obtain badges and programs at the Registration Desk in the Municipal Auditorium. No one will be admitted to the Auditorium Exhibit Hall or Meeting Room or other MAG functions without an MAG Official Registration Badge.

### MAG Scientific Sessions

MAG Scientific Section and Joint Section Meetings will convene on Sunday afternoon, May 8 from 2:00 P.M. to 5:00 P.M. with one Section Meeting also scheduled for Monday afternoon, May 9 from 2:30 P.M. to 5:00 P.M.

The Association will inaugurate a single General Scientific Meeting for all members on Monday after-

noon, May 9 from 2:30 P.M. to 5:00 P.M. at the Municipal Auditorium. An outstanding Symposium on Geriatrics has been scheduled for this General Scientific Session.

### MAG Socio-Economic Session

A timely General Socio-Economic Session for all members has been planned on the subject "Symposium on the New Medicare Law—An Explanation of the Rules and Regulations." As "Medicare" goes into effect July 1, 1966, MAG believes this program to be of special import to the profession. This session will be held Monday morning, May 9 from 10:30 A.M. to 12:00 NOON in the Municipal Auditorium meeting room.

### GaMPAC General Session

The Georgia Medical Political Action Committee has slated a program of great interest to the profession to be held on Monday, May 9 from 12:00 NOON to 12:45 P.M. in the Municipal Auditorium. All MAG members and their guests are welcome to hear outstanding speakers keynote a session devoted to political activity.

### MAG General Business Sessions

The Association will convene its three traditional General Business Sessions in the Municipal Auditorium meeting room. The First General Business Session for all MAG Members will be held Sunday afternoon, May 8 at 5:00 P.M. at which time nominations for Association Office will be presented. The Second MAG General Business Session will be convened jointly with the MAG House of Delegates meeting on Monday morning, May 9 from 9:00 A.M. to 10:30 A.M. During this second business session, the MAG President-Elect will outline his program for Association activity in 1966-67. The third and final MAG General Business Session will also convene jointly with the House of Delegates on Tuesday morning, May 10 at 9:00 A.M. when awards will be presented, election results announced, and new officers installed. Business Sessions will precede House of Delegates' deliberations at both of the joint meetings.

### MAG House of Delegates Sessions

All sessions of the MAG House of Delegates will be held at the Municipal Auditorium meeting room. The



first session of the House will be convened on Monday morning, May 9 at 9:00 A.M. to 10:30 A.M. in conjunction with the MAG Business Session. At this first session, all reports and resolutions will be introduced for referral to Reference Committees of the House.

All Reference Committees will meet concurrently on Monday afternoon, May 9 at 2:30 P.M. in the Ralston Motor Hotel. Delegates and MAG members alike are urged to attend the Reference Committee meetings so that they may make their views known to assist these Committees in their deliberations on the items of business referred to them.

The second session of the House of Delegates will convene Tuesday morning, May 10 from 9:00 A.M. until adjournment at NOON. At this last session, the House Reference Committees will report their recommendations and the House will vote to set MAG policy for the Association.

Delegates are urged to attend both sessions of the House to fulfill their responsibility to the County Medical Societies they represent. *All Delegates are requested to attend both sessions of the House at least 15 minutes prior to the time they are convened so that the Delegates may be registered as "voting members" of the House.* Registration of MAG Delegates will be conducted at a SPECIAL DELEGATES REGISTRATION DESK just inside the Municipal Auditorium meeting room. The House Credentials Committee will verify Delegates' Credentials Cards so that "voting privileges" may be recognized by each Delegate receiving a *Special Delegates Badge*. A "reserved seating area" will be provided for voting Delegates and their Special Delegates Badge will admit them to this area in the meeting room.

### MAG Message Center

A Message Center will be maintained at the MAG Registration Desk at the entrance to the Municipal Auditorium for the convenience of the membership. Pages from the Woman's Auxiliary to MAG will staff this center during the entire Annual Session. An Official MAG Bulletin Board will also be available at the Message Center for notices of special importance.

### MAG Headquarters Office and Press Room

The Association Headquarters Office Staff will maintain a Headquarters Office Room adjacent to the meeting room at the Municipal Auditorium. Staff secretarial activities will be conducted in this room in conjunction with the business of the Association during the Annual Session.

The Association will also maintain a "Press Room" at the Municipal Auditorium for newspaper, radio and T.V. personnel during the MAG meetings.

### MAG Memorial Services

The Medical Association of Georgia will hold its traditional annual Memorial Service at the Joint General Business Session and House of Delegates meeting on Monday morning, May 9 at 9:00 A.M. in the Municipal Auditorium meeting room. All members and their guests are invited to attend this service which is held in memory of those members who have died during the past Association year. The event will honor and recall the dedicated service and contributions of the following medical practitioners:

Guy H. Adams, Atlanta, April 22, 1965  
Allen H. Bunce, Atlanta, July 30, 1965

F. Phinzy Calhoun, Atlanta, May 9, 1965  
M. L. B. Clarke, Atlanta, November 8, 1965  
H. Lumpkin Coffee, Forsyth, August 8, 1965  
Allen A. Cole, Macon, November 2, 1965  
G. K. Cornwell, Fitzgerald, August 4, 1965  
Joseph G. Crovott, Camilla  
Charles E. Hall, Jr., Atlanta, November 6, 1965  
J. H. Hodges, Atlanta, January 31, 1966  
Fred G. Hodgson, Atlanta, December 5, 1965  
P. M. Howard, College Park, November 25, 1965  
G. Pope Huguley, Atlanta, June 23, 1965  
Thomas H. Johnston, Brunswick, June 20, 1965  
William G. Keiter, Greensboro, October 29, 1965  
James H. Kelley, Newnan, March 2, 1965  
F. D. Kennedy, Baxley, December 19, 1965  
E. M. Lancaster, Shady Dale, April 2, 1965  
Thomas F. Lawless, Savannah, November 27, 1965  
R. S. Leadingham, Milwaukee, Wisconsin, February 3, 1966  
O. D. Lennard, Sandersville, November 16, 1965  
Merrill I. Lineback, East Point, December 21, 1964  
J. C. Logan, Plains, August 15, 1965  
R. H. Oppenheimer, Jacksonville, Florida, January 21, 1966  
Nicholes Overby, Sandersville, December 28, 1965  
W. P. Phillips, LaGrange, April 16, 1965  
Charles L. Prince, Savannah, July 12, 1965  
Jeff L. Richardson, Atlanta, May 9, 1965  
C. A. Rhodes, Atlanta, October 10, 1965  
Allen I. Robbins, Homerville, July 24, 1965  
J. Elliott Scarborough, Atlanta, January 31, 1966  
R. S. Smith, Macon, June 28, 1965  
Lorin Van Strickland, Cobbtown, June 19, 1965  
W. W. Turner, Nashville, July 21, 1965  
J. P. Tye, Albany, March 25, 1965  
G. W. Willis, Ocilla, January 10, 1965  
L. E. Williams, Cordele, March 23, 1965  
W. A. Williams, Sr., Macon, December 25, 1965  
Jesse H. York, Atlanta, December 23, 1965  
C. R. Youmans, Hazelhurst, August 22, 1965

### Specialty Society Meetings, Luncheons, and Dinners

Specialty Societies have planned meetings, luncheons and dinners for the membership of their organizations to be held in conjunction with the MAG Annual Session. These events are listed in the Official MAG Program, in order of the date and time the event is scheduled—under *Related Events*. As these sessions are limited to the membership of the specialty society sponsoring the affair, they are not considered a part of the MAG Program and are printed in "box form" in the MAG Program to distinguish them from MAG sessions.

### MAG Social Events

Two social events are scheduled by MAG for the membership and their guests during the Annual Session. The Muscogee County Medical Society will host the membership, wives and guests at a Social Hour to be held Monday evening, May 9 at 6:30 P.M. to 7:30 P.M. at the Ralston Motor Hotel. This Social Hour is sponsored by the Royal Crown Cola Company of Columbus.

The MAG will honor its President at the traditional MAG President's Banquet to be held Monday evening, May 9 at 8:00 P.M. at the Ralston Motor Hotel. The Banquet will follow the Muscogee County Medical Society Social Hour. As space for this Banquet is limited, members are urged to purchase their Banquet tickets on Sunday, May 8—at the MAG Registration Desk. Accordingly, Banquet tickets will be sold on a "first come, first served" basis until the capacity of the banquet hall is reached.

Members of the House of Delegates and their wives and Commercial Exhibitors and their wives will be honored at an MAG Social Hour to be held on Sunday evening, May 8 at 5:30 P.M. Tickets to this Social Hour



will be distributed by MAG to both the MAG Delegates and Commercial Exhibitors prior to this gala affair.

## Golf Tourney

A Golf Tourney will be held at the Columbus Country Club, Cherokee Avenue, Columbus. Tourney play may be scheduled for either Sunday, May 8 or Monday morning until 12:00 NOON, May 9. Members wishing to play should check with Club Golf Pro, Mr. Charlie Harper, or the Assistant Pro, Mr. Cary Rich. If play on Sunday afternoon, May 8 is preferred, it will be necessary to write the Pro at the Club for a specific starting time. Physicians are encouraged to play either Sunday or Monday mornings. Tourney awards will be presented at the MAG President's Banquet, Monday evening, May 9 at 8:00 P.M.

## Scientific Exhibits

Scientific Exhibits will be displayed in the Exhibit Hall of the Municipal Auditorium just adjacent to the Auditorium meeting room. These scientific exhibits are prepared by physicians who will be at their exhibits to discuss their presentations with the membership. All physicians are urged to visit each scientific exhibit in the interests of professional education. Awards for outstanding scientific exhibits will be presented at the final MAG General Business Session on Tuesday morning, May 10 at 9:00 A.M. in the Municipal Auditorium meeting room.

## Commercial Exhibits

Commerical Exhibits will be displayed in the Exhibit Hall of the Municipal Auditorium adjacent to the Auditorium meeting room. The Exhibit Hall will be used to gain both entrance and exit to the Auditorium meeting room. These exhibits will provide technical information of importance to the practice of medicine on products and services available to the medical profession.

*It is extremely important that every member visit each of these exhibits and register with the exhibitor. Your cooperation is urged and requested as these displays are specially designed to benefit the profession. Commercial exhibitors play an extremely important role in making the MAG Annual Session possible through their support of the meeting. Your MAG Commercial Exhibitors Committee asks that all physicians be sure to visit and register at all Commercial Exhibit Booths.*

A list of Commercial Exhibitors and contributors already participating in the MAG 1966 Annual Session is as follows:

Booth No.	Name of Firm
1	Warren-Teed Pharmaceuticals, Inc., Columbus, Ohio
2	William P. Poythress & Company, Inc., Richmond, Virginia
3	Smith, Miller & Patch, Inc., New York, New York
4	Astra Pharmaceutical Products, Inc., Worcester, Mass.
5	U. S. Vitamin & Pharmaceutical Corporation, New York, N. Y.
6	Schering Corporation, Bloomfield, New Jersey
7	American Surgical Supply Company, Atlanta, Georgia
9	Americana Corporation, Beverly Hills, California
0	G. D. Searle & Company, Chicago, Illinois

- 11 Ortho Pharmaceutical Corporation, Raritan, New Jersey
- 12 Durr Surgical Supply Company, Montgomery, Alabama
- 13 Merck, Sharp & Dohme, Jacksonville, Florida
- 14 CIBA Pharmaceutical Company, Summit, New Jersey
- 15 E. R. Squibb & Sons, New York, N. Y.
- 16 Medco Products Company, Atlanta, Georgia
- 19 Life Insurance Company of Georgia, Atlanta, Georgia
- 20 Endo Laboratories, Inc., Garden City, New York
- 21 The Christopher Company, Columbus, Georgia
- 22 Geigy Pharmaceuticals, New York, N. Y.
- 23 Mead Johnson Laboratories, Evansville, Indiana
- 24 Davies, Rose-Hoyt, Needham Heights, Mass.
- 25 Sandoz Pharmaceuticals, Hanover, New Jersey
- 26 Parke, Davis & Company, Detroit, Michigan
- 27 Wachtel's Physician Supply Company, Savannah, Georgia
- 34 Barnes-Hind Laboratories, Sunnyvale, California
- 35 The Upjohn Company, Kalamazoo, Michigan
- 36 Delta Drug Corporation, Jacksonville, Florida
- 37 The Coca-Cola Company, Atlanta, Georgia
- 38 Abbott Laboratories, North Chicago, Illinois
- 39 Carnation Company, Los Angeles, California
- 40 Hewlett-Packard Company, Sanborn Division, Wal-ton, Mass.
- 41 Mayrand, Inc., Greensboro, N. C.
- 42 A. H. Robins Company, Inc., Richmond, Virginia
- 47 Physicians Products Company, Inc., Petersburg, Virginia
- 48 Medics Pharmaceutical Corp., Decatur, Georgia

The following firms have contributed funds to the Association for direct use in programming scientific speakers at this Annual Session:

Eli Lilly and Company, Indianapolis, Indiana  
Smith Kline and French Laboratories, Philadelphia, Pennsylvania

## Fifty Year Members

Physician members who have practiced medicine for 50 years will be honored at the MAG Annual Session by the award of a 50-Year Pin and Certificate. These awards will be presented at the final MAG General Business Session on Tuesday morning, May 10 at the Municipal Auditorium meeting room. The following list contains the names of members of the Medical Association of Georgia who, as of the year 1966, have practiced medicine for 50 years. It does not include physicians who have already received gold membership cards. The list includes only those members in the Class of 1916 who were also licensed in Georgia in 1916 as follows:

Claude A. Almand	Atlanta
Thomas J. Busey	Fayetteville
Ernest Corn	Macon
George H. Faggart	Savannah
Conway W. Hunter, Sr.	Atlanta
James L. King, Sr.	Macon
Samuel L. Morris	Atlanta
Lum G. Neal, Sr.	Cleveland
Virgil W. Osborne	Atlanta
Albert A. Rayle, Sr.	Atlanta
Robert L. Rhodes	Augusta
Relliford S. Smith	Macon
William A. Williams	Macon



# For Your MAG 1966 Annual Session Hotel & Motel Reservations

## APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS

Medical Association of Georgia 112th Annual Session

May 8-10, 1966—Columbus, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Columbus for the 1966 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodation information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure; (3) names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Housing Bureau. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible to secure the accommodations you request. All reservations will be confirmed.

**Ralston Motor Hotel, Inc.:** 12th Street and 2nd Avenue (322-7331) 250 rooms; **Single \$6 to \$8; Double \$8 to \$10; Twin \$9 to \$12;** air conditioned; television and background music; Coffee Shop and Dining Room—open 6:30 A.M.-11:00 P.M.; Chart Room Lounge for Lunch and Beverages—open 11:00 A.M.-1:00 A.M., downtown Columbus.

**Martinique Motor Hotel:** 1011 4th Avenue (322-6641) 198 rooms; **Single \$8 to \$10; Double \$11 to \$13; Twin \$13 to \$16; Deluxe Studio Rooms \$13 up;** air conditioned; background music; TV in every room; room telephones; two restaurants; swimming pool; Grand Prix Lounge; package store on premises; barber shop; valet laundry service; downtown Columbus.

**Downtowner Motor Inn:** 1325 4th Avenue (322-2522) 99 rooms; **Single \$8 up; Double \$10.50; Twin \$12; Suites \$18 up;** air conditioned; background music; TV in every room; room telephones; 24 hour switchboard; restaurant 6 A.M. to 10 P.M.; swimming

pool; steam room—massuer; Boar's Head Lounge; package store on premises; downtown Columbus.

**Heart of Columbus Motel, Inc.:** 1024 4th Avenue (324-3694) 42 rooms; **Single \$7; Double \$9; Twin \$11;** air conditioned; room telephones; adjoining restaurant; TV in every room, downtown Columbus.

**Holiday Inn of America:** 3170 Victory Drive (689-6181) 184 rooms; **Single \$7 and \$8; Double \$9.50; Twin \$11 and \$12.50; Executive Room \$12.50;** air conditioned; TV in every room; background music; room telephones; restaurant; swimming pool; 3 miles from downtown Columbus.

**Howard Johnson's Motor Lodge:** 3181 Victory Drive (689-7580) 50 rooms; **Single \$9 and \$10; Double \$10; Twin \$12; Family Units \$14 to \$16;** air conditioned; background music; TV in every room; room telephones; lounge; swimming pool; putting green; Howard Johnson's Restaurant next door; 3 miles from downtown Columbus.

Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made.  
Deposit of one day's room rent will be required with each request for accommodations.

Cut out and send to:

Please Type or Print

HOUSING BUREAU, MEDICAL ASSOCIATION OF GEORGIA

Ralston Motor Hotel, Columbus, Georgia

Please reserve the following accommodations for the 1966 Annual Session of the

Medical Association of Georgia.

### Hotel or Motel Preference

1st Choice ..... ☐ Double Room at \$..... to \$.....  
2nd Choice ..... ☐ Double Room at \$..... to \$.....  
3rd Choice ..... ☐ Twin Bedroom at \$..... to \$.....  
..... ☐ Other Type .....

Arrival Date ..... Hour ..... A.M. .... P.M.

Departure Date ..... Hour ..... A.M. .... P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include all names of all persons for whom you are requesting reservations and who will occupy the room(s):

Name of Occupant(s)

Address

### Individual Requesting Reservations

Name .....

Address .....

City ..... State .....

Zip Code .....

*If hotels or motels of your choice are unable to accept your reservations, the Housing Bureau will make reservations to fit your specifications elsewhere.*



# THE PROGRAM

## SATURDAY, MAY 7

### RELATED EVENTS

(Not a part of Official Program)

**NOTE:** Make Reservations in Advance with Chairman if possible.

- 2:00 Georgia Chapter, American Academy of Pediatrics Business Meeting  
*Holiday Inn, Callaway Gardens, Pine Mountain, Georgia*  
Joseph H. Patterson, Atlanta, Chairman
- 2:30 Georgia Society of Anesthesiologists Clinical Session  
*Ralston Motor Hotel*  
Dan C. Newberry, Columbus, Chairman  
Cyclopropane  
Karl L. Siebecker, Madison, Wisconsin
- 6:30 Georgia Chapter, American Academy of Pediatrics Social Hour and Dinner  
*Holiday Inn, Callaway Gardens, Pine Mountain, Georgia*  
Joseph H. Patterson, Atlanta, Chairman
- 6:45 Georgia Society of Anesthesiologists Social Hour  
*Ralston Motor Hotel*  
Dan C. Newberry, Columbus, Chairman
- 7:00 Georgia Society of Dermatologists Dinner  
*Room 207, Downtowner Motor Inn*  
Edgar B. Smith, Fort Benning, Chairman
- 7:00 Georgia Radiological Society Social Hour and Dinner  
*Big Eddy Country Club*  
George M. Hutto, Columbus, Chairman
- 8:00 Georgia Society of Anesthesiologists Dinner  
*Ralston Motor Hotel*  
Dan C. Newberry, Columbus, Chairman

## SUNDAY, MAY 8

### RELATED EVENTS

(Not a part of Official Program)

**NOTE:** Make Reservations in Advance with Chairman if possible.

- 9:00 Georgia Society of Dermatologists Clinical Cases Presentation  
*Out-Patient Clinic, The Medical Center*  
Edgar B. Smith, Fort Benning, Chairman
- 9:30 Georgia Radiological Society Business Meeting  
*Ralston Hotel*  
George M. Hutto, Columbus, Chairman
- 10:00 Georgia Association of Pathologists Business Meeting  
*Grand Prix Lounge, Martinique Motor Hotel*  
Agatha Thrash, Columbus, Chairman
- 10:30 Georgia Society of Dermatologists Business Meeting  
*Auditorium, The Medical Center*  
Edgar B. Smith, Fort Benning, Chairman
- 10:30 Georgia Society of Anesthesiologists Business Meeting  
*Ralston Motor Hotel*  
Dan C. Newberry, Columbus, Chairman
- 11:00 Registration, Georgia Pediatric Society and Georgia Chapter, American Academy of Pediatrics  
*Entrance, Civic Room, Ralston Motor Hotel*

- 12:00 Georgia Pediatric Society Business Meeting and Luncheon  
*Civic Room, Ralston Motor Hotel*  
A. J. Kravtin, Columbus, Chairman
- 12:00 Georgia Psychiatric Association Luncheon Meeting  
*Ralston Motor Hotel*  
Leonard T. Maholick, Columbus, Chairman
- 12:30 Georgia Society of Dermatologists Luncheon  
*Room 207, Downtowner Motor Inn*  
Edgar B. Smith, Fort Benning, Columbus
- 12:30 Georgia Chapter, American College of Chest Physicians and Georgia Thoracic Society Luncheon Meeting  
*Martinique Motor Hotel*  
Robert H. Vaughan, Columbus, Chairman
- 12:30 Georgia Association of Pathologists Luncheon  
*Grand Prix Lounge, Martinique Motor Hotel*  
Agatha Thrash, Columbus, Chairman
- 1:00 Georgia Orthopedic Society Luncheon  
*Rooms 250-251, Martinique Motor Hotel*  
George Whatley, Columbus, Chairman

## SUNDAY AFTERNOON, MAY 8

- 2:00 General Practice, Medicine, Diabetes and Ophthalmology & Otolaryngology Joint Section Meeting  
(ALL PHYSICIANS INVITED)  
*Municipal Auditorium*  
PRESIDING  
Simone Brocato, Columbus
- 2:00 CHRONIC CONSTRICTIVE PERICARDITIS  
Robert L. Parker, Rochester, Minnesota
- 2:40 INSULIN, RECENT ADVANCES  
George J. Hamwi, Columbus, Ohio
- 3:10 PSYCHOGENIC PAIN  
E. James McCranie, Augusta
- 3:40 RECESS
- 3:55 GANGRENE OF THE HEEL WITH DIABETES. ARTERIAL RECONSTRUCTION, THE CONSERVATIVE APPROACH  
Robert I. Lowenberg, Atlanta
- 4:05 THE OPHTHALMOSCOPIC FINDINGS IN CERTAIN SYSTEMIC DISORDERS  
William S. Hagler, Atlanta
- 2:00 Surgery and Orthopedics Joint Section Meeting  
(ALL PHYSICIANS INVITED)  
*Grand Ballroom, Martinique Motor Hotel*  
PRESIDING  
Charles H. Richardson, Jr., Macon
- 2:00 CHRONIC ULCERATIVE DISEASE OF THE INTESTINE—A 15 YEAR SURGICAL EXPERIENCE IN COLUMBUS  
A. B. Conger, Columbus
- 2:20 THE MANAGEMENT OF THE SEVERELY INJURED  
Oscar Creech, Jr., New Orleans, Louisiana
- 2:50 SURGICAL TREATMENT OF PEPTIC ULCER AT TALMADGE HOSPITAL  
Edwin L. Brackney, Augusta



- 3:10 LOWER EXTREMITY AMPUTATIONS AT GRADY MEMORIAL HOSPITAL—A TEN YEAR STUDY  
John N. McClure, Atlanta
- 3:30 FACET FRACTURE FOLLOWING DISC SURGERY  
Fred P. Sage, Memphis, Tennessee
- 3:50 DISCUSSION
- 4:00 COMPLICATIONS OF PLASTER AND TRACTION  
James W. Harkess, Augusta
- 4:15 DISCUSSION
- 4:20 SALVAGE OF THE SEVERELY INJURED HAND  
Grady S. Clinkscales, Jr., Atlanta
- 4:35 DISCUSSION
- 4:40 TEAM PHYSICIAN IN HIGH SCHOOL ATHLETICS  
George S. Whatley, Columbus
- 4:55 DISCUSSION
- 2:00 Radiology, Anesthesiology and Chest Joint Section Meeting  
(ALL PHYSICIANS INVITED)  
*Auditorium, The Medical Center*  
PRESIDING  
Curtis H. Carter, Augusta
- 2:00 THE PREPARATION OF THE PATIENT WITH PULMONARY DISEASE FOR ANESTHESIA  
Karl L. Siebecker, Madison, Wisconsin
- 2:30 RECURRENT PULMONARY EMBOLISM: CURRENT DIAGNOSTIC AND THERAPEUTIC CONCEPTS  
Ben V. Branscomb, Birmingham, Alabama
- 2:50 PHYSICAL REHABILITATIVE ASPECTS FOLLOWING ACUTE CHEST TRAUMA (OPERATIVE AND OTHERWISE)  
Albert Haas, New York, New York
- 3:10 70 MM. SPOT FILMING IN RADIOLOGICAL DIAGNOSIS—ADVANTAGES AND LIMITATIONS  
Richard A. Elmer, Atlanta
- 3:30 RECESS
- 3:45 PANEL ON X-RAY  
MODERATOR  
C. M. Silverstein, Atlanta  
PANEL  
Ben V. Branscomb, Birmingham, Alabama  
Robert G. Ellison, Augusta  
Donald M. Callahan, Ft. Benning, Georgia
- 2:00 Pediatric Section Meeting  
(ALL PHYSICIANS INVITED)  
*Civic Room, Ralston Motor Hotel*  
PRESIDING  
Martin H. Smith, Gainesville
- 2:00 MODERN TOOLS IN PEDIATRIC CARDIOLOGY  
Alexander Nadas, Boston, Massachusetts
- 2:45 EVALUATION OF THE CYANOTIC INFANT  
Gordon Folger, Augusta
- 3:30 RECESS
- 3:45 HEART MURMURS IN THE NEWBORN PERIOD  
Dorothy Brinsfield, Atlanta
- 4:15 PANEL ON PEDIATRIC CARDIOLOGY  
MODERATOR

Joseph H. Patterson, Atlanta  
PANELISTS  
Alexander Nadas, Boston, Massachusetts  
Gordon Folger, Augusta  
Dorothy Brinsfield, Atlanta  
F. Kathryn Edwards, Atlanta

- 2:00 Psychiatry Section Meeting  
(ALL PHYSICIANS INVITED)  
*Rooms 324-26-28, Ralston Motor Hotel*  
PRESIDING  
Jack A. Raines, Columbus
- 2:00 GEORGIA'S MENTAL HEALTH PROGRAM: IMPLICATIONS FOR THE PRACTICE OF MEDICINE (A PANEL DISCUSSION)  
PUBLIC HEALTH PHILOSOPHY OF MENTAL HEALTH PROGRAM  
John H. Venable, Atlanta  
PRESENT AND FUTURE MENTAL HEALTH PROGRAMS  
Addison M. Duval, Atlanta  
THE PRIVATE PRACTICE FAMILY PHYSICIAN VIEWS THE PROGRAM  
W. D. Stribling, Gainesville  
THE PRIVATE PRACTICE PSYCHIATRIST VIEWS THE PROGRAM  
Jack A. Raines, Columbus  
GENERAL DISCUSSION BY THE AUDIENCE
- 2:00 Dermatology and Pathology Joint Section Meeting  
(ALL PHYSICIANS INVITED)  
*Gold and Green Room, Ralston Motor Hotel*  
PRESIDING  
Edgar B. Smith, Fort Benning
- 2:00 SKIN MANIFESTATIONS OF SYSTEMATIC DISEASES  
Leonard B. Starr, Fort Benning
- 2:20 PRESENT IMPLICATIONS OF THE SING-SIN STUDY ON HUMAN INOCULATION WITH SYPHILIS  
Sidney Olansky, Atlanta
- 2:40 RECENT TRENDS IN DERMATOLOGIC THERAPY  
Harvey Blank, Miami, Florida
- 3:15 RECESS
- 3:20 THE APPLICATION OF THE FLUORESCENT ANTIBODY TECHNIQUE TO THE DIAGNOSIS OF SPOROTRICHOSIS, HISTOPLASMOSIS AND NORTH AMERICAN BLASTOMYCOSIS  
William Kaplan, Atlanta
- 3:35 SOME SPECIAL CONSIDERATIONS OF METASTASIZING SKIN TUMORS  
Herbert Z. Lund, Greensboro, North Carolina
- 4:10 PANEL ON FUNGUS INFECTIONS  
MODERATOR  
Agatha Thrash, Columbus  
PANELISTS  
William L. Dobes, Atlanta  
Herbert Z. Lund, Greensboro, North Carolina  
Harvey Blank, Miami, Florida  
Leonard B. Starr, Fort Benning, Georgia  
William Kaplan, Atlanta  
Sidney Olansky, Atlanta



- 2:00 Public Health Section Meeting**  
(ALL PHYSICIANS INVITED)  
*Muscogee County Health Department Building*  
PRESIDING  
Robert J. Walker, Macon
- 2:15 HOSPITAL AND HEALTH PLANNING**  
R. C. Williams, Atlanta
- 2:35 FAMILY PLANNING**  
Nicholas Wright, Atlanta
- 2:55 THE OPPORTUNITY FOR PREVENTIVE MEDICINE IN OBSTETRICS**  
J. R. Swartwout, Atlanta
- 3:45 RECESS**
- 4:00 IMPACT OF MEDICARE**  
John H. Venable, Atlanta
- 5:00 MAG General Business Session**  
(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)  
*Municipal Auditorium Meeting Room*  
PRESIDING  
George H. Alexander, Forsyth, President  
Medical Association of Georgia
- NOMINATIONS OF OFFICERS AND COUNCILORS  
(*Announcement of Tellers Committee*)  
President-Elect  
Second Vice President  
Secretary (To serve until 1969)  
First District Councilor (To serve until 1967)  
First District Vice Councilor (To serve until 1967)  
Second District Councilor (To serve until 1967)  
Second District Vice Councilor (To serve until 1967)  
Third District Councilor (To serve until 1967)  
Third District Vice Councilor (To serve until 1967)  
Fourth District Councilor (To serve until 1967)  
Fourth District Vice Councilor (To serve until 1967)  
Sixth District Councilor (To serve until 1968)  
Sixth District Vice Councilor (To serve until 1968)  
Seventh District Councilor (To serve until 1968)  
Seventh District Vice Councilor (To serve until 1968)  
Eighth District Councilor (To serve until 1968)  
Eighth District Vice Councilor (To serve until 1968)  
Ninth District Councilor (To serve until 1969)  
Ninth District Vice Councilor (To serve until 1969)  
Tenth District Councilor (To serve until 1969)  
Tenth District Vice Councilor (To serve until 1969)  
Bibb County Medical Society Councilor (To serve until 1969)  
Bibb County Medical Society Vice Councilor (To serve until 1969)

- Cobb County Medical Society Councilor (To serve until 1969)  
Cobb County Medical Society Vice Councilor (To serve until 1969)  
DeKalb County Medical Society Councilor (To serve until 1969)  
DeKalb County Medical Society Vice Councilor (To serve until 1969)  
Fulton County Medical Society Councilor (To serve until 1967)  
Fulton County Medical Society Vice Councilor (To serve until 1967)  
Fulton County Medical Society Councilor (To serve until 1969)  
Fulton County Medical Society Vice Councilor (To serve until 1969)  
Richmond County Medical Society Councilor (To serve until 1969)  
Richmond County Medical Society Vice Councilor (To serve until 1969)  
AMA Delegate (Term beginning January 1, 1967 and expiring December 31, 1969)  
AMA Alternate Delegate (Term beginning January 1, 1967 and expiring December 31, 1969)  
AMA Delegate (Term beginning January 1, 1967 and expiring December 31, 1969)  
AMA Alternate Delegate (Term beginning January 1, 1967 and expiring December 31, 1969)  
AMA Delegate (Term beginning January 1, 1967 and expiring December 31, 1969)  
AMA Alternate Delegate (Term beginning January 1, 1967 and expiring December 31, 1969)  
Nominations for Awards:  
General Practitioner of the Year Award (To be voted on by House of Delegates)

## SUNDAY EVENING, MAY 8

**5:30 Delegates and Exhibitors Social Hour**  
(*Site to be announced*)

## SUNDAY EVENING, MAY 8

### RELATED EVENTS

(Not a part of Official Program)

*NOTE: Make Reservations in Advance with Chairman if possible.*

- 6:30** Medical College of Georgia Alumni Social Hour and Dinner  
*Social Hour at Poolside; Dinner in Grand Ballroom, Martinique Motor Hotel*  
Roy L. Gibson, Columbus, Chairman
- 6:30** Emory University Medical Alumni Association Social Hour and Dinner  
(*To be announced*)  
Haywood Turner, Columbus, Chairman
- 6:30** University of Virginia Alumni Social Hour and Dinner  
(*To be announced*)  
See Mr. William Booth, University of Virginia Alumni, in Registration area for details.
- 7:00** Georgia Chapter, American Association of Public Health Physicians Dinner  
*Fort Benning Officers Open Mess*  
Joe A. Bain, Columbus, Chairman



## MONDAY MORNING, MAY 9

- 9:00 MAG General Business Session and House of Delegates Meeting**  
(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)  
*Municipal Auditorium Meeting Room*
- 8:45 MAG DELEGATES REGISTRATION**  
*Auditorium Meeting Room Entrance*
- 9:00 GENERAL BUSINESS SESSION**  
PRESIDING  
George H. Alexander, Forsyth, President  
Medical Association of Georgia
- INVOCATION  
Dr. Sidney A. Gates, Pastor  
First Presbyterian Church, Columbus
- WELCOME  
Louis A. Hazouri, President  
Muscogee County Medical Society
- GREETINGS  
Honorable B. Ed Johnson, Mayor  
City of Columbus
- OUR ASSOCIATION FUTURE FOR 1966-67  
Walter E. Brown, Savannah, President-Elect  
Medical Association of Georgia
- REPORT OF THE AUXILIARY  
Mrs. John A. Meier, Albany, President-Elect, for Mrs. Louie H. Griffin, Sr., Claxton, President
- MAG MEMORIAL SERVICE  
HOUSE OF DELEGATES MEETING  
PRESIDING  
J. Frank Walker, Atlanta  
Speaker of the House
- ORDER OF BUSINESS (See Delegates Handbook)

## MONDAY, MAY 9

- 10:30 MAG General Session on Medical Socio-Economics**  
(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)  
*Municipal Auditorium Meeting Room*
- PRESIDING  
Henry S. Jennings, Gainesville
- SYMPOSIUM ON THE NEW MEDICARE LAW  
—AN EXPLANATION OF THE RULES AND REGULATIONS
- 10:30 MEDICARE—WHERE IT'S BEEN AND WHERE IT'S GOING**  
Mr. Douglass Richard, Regional Representative, Bureau of Health Insurance, Social Security Administration, Atlanta
- 10:45 MEDICARE RESPONSIBILITY OF THE STATE ADMINISTRATIVE AGENCY**  
John H. Venable, Director, State Department of Public Health, Atlanta
- 11:00 ROLE OF THE 'CARRIER' UNDER MEDICARE PART A—HOSPITAL BENEFITS**  
Speaker to be Announced as Designated by HEW
- 11:15 ROLE OF THE 'CARRIER' UNDER MEDICARE PART B—PHYSICIAN SERVICES**

Mr. Lawrence B. Gilman, Vice President,  
John Hancock Mutual Life Insurance Co.,  
Boston, Massachusetts

- 11:30 MEDICAL SERVICES FOR PUBLIC ASSISTANCE RECIPIENTS**  
Mrs. Bruce Schaefer, Director, State Department of Family and Children Services, Atlanta
- 11:45 QUESTIONS AND ANSWERS**
- 12:00 GaMPAC**  
(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)  
*Municipal Auditorium Meeting Room*
- PRESIDING  
John T. Mauldin, Atlanta  
(Speaker to be announced)

## MONDAY AFTERNOON, MAY 9

### RELATED EVENTS

(Not a part of Official Program)

*NOTE: Make Reservations in Advance with Chairman if possible.*

- 12:30 Georgia Chapter, American College of Surgeons Luncheon**  
*Downtowner Motor Inn*  
S. A. Roddenbery, Columbus, Chairman
- 1:00 Georgia State Obstetrical and Gynecological Society Business Meeting and Luncheon**  
*Martiniue Motor Hotel*  
John R. McCain, Atlanta, Chairman
- 1:00 Georgia Diabetes Association, Georgia Society of Internal Medicine and Georgia Chapter, American College of Physicians Luncheon and Business Meeting**  
*Martiniue Motor Hotel*  
Harry Brill, Columbus, Chairman

## MONDAY, MAY 9

- 2:30 MAG REFERENCE COMMITTEES**  
Reference Committees No. 1, No. 2, No. 3  
No. 4, No. 5 and No. 6  
*Ralston Motor Hotel, Room 319, Green Room, Gold Room, Old Gold Room, Room 219 and No. 6 room to be designated*

## MONDAY AFTERNOON, MAY 9

- 2:30 MAG Scientific General Session**  
(ALL PHYSICIANS INVITED)  
*Municipal Auditorium Meeting Room*
- PRESIDING  
C. Denton Johnson, Columbus
- SYMPOSIUM ON GERIATRICS
- 2:30 SALVAGE OF THE ISCHEMIC LIMB BY ARTERIAL RECONSTRUCTION**  
Oscar Creech, Jr., New Orleans, Louisiana
- 3:00 OSTEOPOROSIS**  
Frederick C. Swartz, Lansing, Michigan
- 3:30 THE MIDDLE-AGED OLD MAN**  
E. James McCranie, Augusta



- 2:30 Obstetrical and Gynecological Section Meeting**  
ing  
(ALL PHYSICIANS INVITED)  
*Civic Room, Ralston Motor Hotel*  
PRESIDING  
C. I. Bryans, Jr., Augusta
- 2:30 A DESCRIPTION OF THE HIGH RISK PREGNANCY PROJECT AT GRADY MEMORIAL HOSPITAL**  
W. Newton Long, Atlanta
- 2:45 PRENATAL AND PERINATAL NEEDS IN GEORGIA**  
John H. Venable, Atlanta,  
Morris E. Brackett, Atlanta, and  
Robert J. Walker, Jr., Macon
- 3:45 ANAEROBIC INFECTIONS IN GYNECOLOGY AND OBSTETRICS**  
Bayard Carter, Durham, North Carolina
- 4:15 PANEL ON VAGINAL APPROACH TO PELVIC PATHOLOGY**  
MODERATOR  
Peter C. Graffagnino, Columbus  
PANEL  
John H. Angell, Savannah  
Bayard Carter, Durham, North Carolina  
Jule C. Neal, Jr., Macon  
W. Vernon Skiles, Jr., Atlanta

## MONDAY EVENING, MAY 9

- 6:30 MUSCOGEE COUNTY MEDICAL SOCIETY SOCIAL HOUR**  
Sponsored by Royal Crown Cola Company of Columbus  
*Ralston Motor Hotel*
- 8:00 MAG PRESIDENT'S BANQUET**  
*Ralston Motor Hotel*

## TUESDAY MORNING, MAY 10

- 9:00 MAG General Business Session and House of Delegates Second Meeting**  
(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)  
*Municipal Auditorium Meeting Room*

- 8:45 MAG DELEGATES REGISTRATION Auditorium Meeting Room Entrance**  
GENERAL BUSINESS SESSION  
PRESIDING  
George H. Alexander, Forsyth, President  
Medical Association of Georgia  
PRESENTATION OF 50 YEAR CERTIFICATES  
J. G. McDaniel, Atlanta  
Immediate Past President  
Medical Association of Georgia  
PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS  
John N. McClure, Atlanta, Chairman  
Scientific Awards Committee  
PRESENTATION OF GENERAL PRACTITIONER OF THE YEAR AWARD  
Don W. Schmidt, Cedartown, President  
Georgia Academy of General Practice  
PRESENTATION OF MAG CERTIFICATES OF APPRECIATION  
John T. Mauldin, Atlanta, Secretary  
Medical Association of Georgia  
PRESENTATION OF HARDMAN AWARD  
Walter E. Brown, Savannah, President-Elect  
Medical Association of Georgia  
PRESENTATION OF MAG DISTINGUISHED SERVICE AWARD  
George H. Alexander, Forsyth, President  
Medical Association of Georgia  
SELECTION OF SITE FOR MAG 1968 ANNUAL SESSION  
ANNOUNCEMENT OF MAG ELECTION RESULTS  
Chairman, Tellers Committee  
INSTALLATION OF 1966-1967 OFFICERS  
George H. Alexander, Forsyth  
Immediate Past President  
Medical Association of Georgia  
HOUSE OF DELEGATES SECOND MEETING  
PRESIDING  
J. Frank Walker, Atlanta  
Speaker of the House  
ORDER OF BUSINESS  
(See Delegates Handbook)  
ADJOURNMENT OF THE HOUSE  
ADJOURNMENT OF 112TH ANNUAL SESSION

## VOTING RULES

### Bylaws, Chapter V, Election of Officers

**BYLAWS, CHAPTER V, ELECTION OF OFFICERS. SECTION 3. METHOD.** The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Each member and no other shall prepare his ballot and

shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

**SECTION 4. TIME.** Voting shall take place during the hours of the scientific program up to the beginning of the last day of the Annual Session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.



# GUEST SPEAKERS



**ROBERT L. PARKER, M.D.**

Rochester, Minnesota

ROBERT L. PARKER, M.D. of the Mayo Clinic, Rochester, Minnesota, will appear at the 112th Annual Session of the Medical Association of Georgia on Sunday afternoon, May 8, at 2:00 P.M. An abstract of his paper, "Chronic Constrictive Pericarditis," for the General Practice, Medicine, Diabetes, and Ophthalmology & Otolaryngology Joint Section Meeting follows:

During the years from 1950 to 1964, 79 patients with chronic constrictive pericarditis underwent pericardectomy at the Mayo Clinic. The age range was from 8 to 70 years, and 70% of the patients were between the ages of 20 and 55 years. The male-to-female ratio was 3 to 1. Tuberculosis was proven to be the causative factor in only 9% of the cases, and in another 9% there was a history of previous single or recurrent episodes of acute non-specific or viral pericarditis. In approximately 80% of the patients, the etiology remained unknown although in 23 patients there was a history of atypical pneumonia, influenza, or pleurisy which appeared to bear some relationship to the onset of pericardial constriction. Roentgenologic evidence of pericardial calcification was present in 43% of the patients, and in the absence of x-ray evidence of pericardial calcification, accurate diagnosis frequently presented a difficult challenge.

The principal clinical features noted were an insidious onset of dyspnea, ascites, and hepatomegaly. Although dyspnea was the primary complaint in 34 patients, the ascites and hepatomegaly present in most patients were of a degree in excess of that which would be expected in the usual patient with congestive heart failure. Peripheral edema was frequently absent even when ascites and hepatomegaly were prominent findings.

Elevation of venous pressure was present in all cases. A rapid Y descent in the jugular venous pulse and protodiastolic third heart sound and paradoxical pulse were undoubtedly present in more cases than actually recorded (30%). Pleural effusion was a common finding and present in 48% of patients—bilateral in most but limited to the right chest in almost as many.

The electrocardiogram was normal in only three patients, the most frequent abnormality being a repolarization abnormality with T wave inversion in mid and left precordial leads (89%). Low voltage QRS complexes in limb and precordial leads were present in 46% of the cases and atrial fibrillation was present in 29%.

In the 23 patients who had cardiac catheterization preoperatively, the principal findings indicating lack of ventricular compliance or impaired ventricular diastolic filling were elevated mean right atrial and right ventricular pressures with a prominent early diastolic dip and plateau in the ventricular pressure curve and a reduced cardiac output. Wedge pressure was elevated in all except one patient indicating the factor of bi-ventricular compression.

It is important to emphasize that all of the clinical features of chronic constrictive pericarditis may be duplicated by other diseases in which diastolic ventricular filling is impeded such as in some patients with primary myocardial pathology, amyloid disease, and endomyocardial fibrosclerosis.

Although pericardectomy offers the only relief for patients with chronic pericardial constriction, unfortunately, the surgical mortality continues to remain high, and unless adequate decortication of both ventricles is done, significant benefit is not achieved.

Dr. Parker is a graduate of Northwestern University Medical School, and served his residency in Internal Medicine at the Mayo Foundation. He is presently Senior Consultant in Internal Medicine (Cardiology), Mayo Foundation, and Associate Professor of Medicine, Mayo Graduate School of Medicine at the University of Minnesota.



**GEORGE J. HAMWI, M.D.**

Columbus, Ohio

GEORGE J. HAMWI, M.D., Columbus, Ohio, will present his paper, "Insulin, Recent Advances," Sunday May 8, at 2:40 P.M. to the General Practice, Medicine Diabetes, and Ophthalmology & Otolaryngology Joint Section Meeting. Dr. Hamwi received his medical education at the American University of Beirut, and his postgraduate degree from Ohio State University. He is presently Professor of Medicine and Director of the Division of Endocrinology and Metabolism, Department of Medicine, College of Medicine, Ohio State University, Columbus, Ohio. He is a member of the American Association for the Advancement of Science and on the Board of Directors of the American Diabetes Association, and a Fellow of the American College of Physicians. A summary of his paper follows:

The recent developments and our knowledge about insulin will be reviewed in the mechanisms of release and its peripheral actions. The possible role of anti-insulin substance in the etiology of diabetes and insulin resistance will also be discussed. In addition, the clinical applications of these recent advances will be presented.



## OSCAR CREECH, JR., M.D.

New Orleans, Louisiana



OSCAR CREECH, JR., M.D., New Orleans, Louisiana, will present two papers to the 112th Annual Session. The first, "The Management of the Severely Injured," will be given before the Surgery and Orthopedics Joint Section Meeting, Sunday, May 8 at 2:20 P.M. The second will be presented to the Symposium on Geriatrics, and is entitled, "Salvage of the Ischemic Limb by Arterial Reconstruction"; time is 2:30 P.M., Monday, May 9. Abstracts of each presentation follow:

### Management of the Severely Injured

Severe injury is defined as one which is life threatening to a single body region or injuries to multiple body regions which require coordinated treatment. All patients in these categories require prompt resuscitation, accurate diagnosis and effective treatment. The management of the severely injured calls for the efforts of the general surgeon and the surgical subspecialist whose efforts must be coordinated. This report is concerned with some of the principles underlying the management of the severely injured patient and a presentation of some cases illustrating these principles.

### Salvage of the Ischemic Limb by Arterial Reconstruction

To improve results of treatment on the Tulane Surgical Service we have extended indications for restoration of arterial flow to include all patients faced with loss of a lower limb provided there was a patent distal segment of artery to which anastomosis could be made. As a result of operation in more than 100 patients amputation was avoided in three-fourths with a mortality rate of only 5%.

## FRED P. SAGE, M.D.

Memphis, Tennessee



FRED P. SAGE, M.D. of the Campbell Clinic, Memphis, Tennessee, will present his paper, "Facet Fractures Following Disc Surgery," at the Surgery and Orthopedics Joint Section Meeting, Sunday, May 8 at 3:30 P.M. A précis follows:

The cause for continued low back pain or recurrent low back pain following disc surgery is always difficult to diagnosis. In one 12 month period of time six facet fractures were found, by the author, in patients who had previously had disc surgery. The facet fractures were always in the vertebra in which a partial laminectomy or a total hemilaminectomy had been performed and were felt to be the cause of the patients' recurrent back discomfort. Four facet fractures followed relatively minor trauma, one was apparently a fatigue frac-

ture in the facet, and the etiology of the remaining facet fracture was not known.

Five of the six patients were subjected to exploratory surgery and treatment by excision of the fractured facet and fusion of the vertebra involved. The fracture that was felt to be a fatigue in type was treated by brace immobilization alone, with a good result.

There is usually a definite chain of symptoms that occurs following facet fractures but the roentgenological identification of such is difficult and uncertain. Nonetheless, another cause for some of the perplexing post-operative disc pain has been found and treated.

Dr. Sage received his medical degree from the University of Tennessee College of Medicine at Memphis. He served his internship and residency at the Shreveport Hospital, Shreveport, Louisiana. He is a Diplomate of the American Board of Orthopaedic Surgery, and is presently, in addition to being at the Campbell Clinic, an Instructor in Orthopaedic Surgery at the University of Tennessee College of Medicine.



## KARL L. SIEBECKER, M.D.

Madison, Wisconsin

KARL L. SIEBECKER, M.D., Madison, Wisconsin, will present his paper, "The Preparation of the Patient with Pulmonary Disease for Anesthesia," at the Radiology, Anesthesiology and Chest Joint Section Meeting, Sunday, May 8 at 2:00 P.M. Dr. Siebecker graduated from the Wisconsin Medical School in 1940. After service in World War II, he did General Practice for three and one-half years before returning to Wisconsin for training in Anesthesia. He has been a full-time Anesthesiologist since that time, and is now Chairman of the Department of Anesthesiology at the University of Wisconsin, Madison. An abstract of his presentation follows:

The use of intermittent positive pressure breathing has grown rapidly in the United States during the past few years. There has also been development of a great variety of apparatus, as well as an increasing incidence of chronic lung disease. The increasing number of elderly individuals, air pollution, and smoking has contributed to this increased incidence.

The usefulness of such therapy has been established in the treatment of asthma, pulmonary edema and atelectasis. In patients in which anesthesia and operation is anticipated an evaluation of their pulmonary status is a necessity. Patients exhibiting chronic bronchitis, emphysema or asthma will benefit greatly from various types of therapy previous to anesthesia and surgery rather than holding therapy until they get into serious pulmonary difficulty in the postoperative period. Diagnosis, methods of treatment and drugs will be discussed.





## BEN V. BRANSCOMB, M.D.

Birmingham, Alabama

BEN V. BRANSCOMB, M.D., Birmingham Alabama, will present his paper, "Recurrent Pulmonary Embolism: Current Diagnostic and Therapeutic Concepts," at the Radiology, Anesthesiology, and Chest Joint Section Meeting, Sunday, May 8, at 2:30 P.M.

Dr. Branscomb received his medical degree from Duke University School of Medicine and served his internship at the University of Chicago Clinics, Chicago. He was an Assistant Resident and Instructor in Medicine at Vanderbilt Hospital, Nashville.

He is currently a Director of the Pulmonary Disease Division, Medical College of Alabama, and Acting Chief, Pulmonary Function Laboratory, VA Hospital, Birmingham. Dr. Branscomb is a member of the American College of Chest Physicians, the American College of Physicians, and the American Thoracic Society.



## ALBERT B. HAAS, M.D.

New York, New York

ALBERT B. HAAS, M.D., New York City, received his medical degree from the Royal Hungarian Medical School, Budapest, Hungary, and served his internship at St. Janos Hospital in Budapest. Before World War II, he served his residency in Pulmonary Diseases at Sanatorium Mont Blanc, Plateau D'Assi, H.S. France, and after the war continued his residency at St. Roch Hospital, Nice, France. He is presently Assistant Clinical Professor of Physical Medicine and Rehabilitation; Director, Cardio-Pulmonary Laboratory, Institute of Physical Medicine and Rehabilitation, New York City.

A précis of his presentation, "Physical Rehabilitative Aspects Following Acute Chest Trauma (Operative and Otherwise)," which will be presented to the Radiology, Anesthesiology, and Chest Joint Section Meeting at 2:50 P.M., Sunday, May 8 follows:

With the development of improved methods of anesthesia and the availability of effective antimicrobial drugs, thoracic surgery has made remarkable advances in the last two decades and thus has become the favored therapeutic approach in pulmonary disease.

However, the most skillfully performed thoracic surgery is bound to leave serious pathologic residua, anatomic and physiologic. In opening the chest wall, the

surgeon, however skilled, is forced to cut through the large muscles of the operative area, muscles that are vitally important in shoulder girdle mobility and trunk posture. During the operation the scapula of the affected side is elevated into a position that tends to overstretch the scapular (both anterior and posterior) muscles.

Furthermore, the fibers of the trapezius, rhomboid major, latissimus dorsi, and serratus anterior muscles are sectioned and, although ultimately repaired, still inevitably show varying degrees of posttraumatic atrophy and dysfunction conducive to progressive structural damage and muscular malfunction with consequent deformity of the trunk.

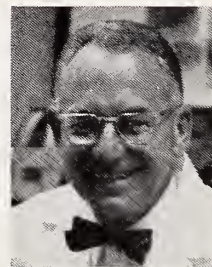


## ALEXANDER S. NADAS, M.D.

Boston, Massachusetts

ALEXANDER S. NADAS, M.D. of the Children's Hospital, Boston, Massachusetts, will present his paper, "Modern Tools in Pediatric Cardiology," to the Pediatric Section Meeting at 2:00 P.M., Sunday, May 8.

Dr. Nadas received one medical degree in 1937 from the Budapest Medical School, Hungary, and the second from Wayne State University School of Medicine, Detroit, Michigan. He was a Research Fellow in Pediatrics at Harvard Medical School, and an Associate Physician and Associate Cardiologist to the Sharon Cardiovascular Unit at the Children's Hospital, Boston. Dr. Nadas' major research interest is in applied cardiovascular physiology and the physiology of congenital heart disease. He is currently Clinical Professor of Pediatrics, Harvard Medical School, Boston.



## HARVEY BLANK, M.D.

Miami, Florida

HARVEY BLANK, M.D., Professor and Chairman, Department of Dermatology, University of Miami School of Medicine, Miami, Florida, was born in Chicago, in 1918; he received his M.D. from the University of Chicago in 1942. After three years as Dermatologist in the U.S. Army in India and Okinawa, he completed his training in this field as a Fellow in the Department of Dermatology, University of Pennsylvania, and became a Diplomate of the American Board of Dermatology in 1948. In 1947, he was a Fellow in Medical Sciences, National Research Council, while doing viral



research at Children's Hospital of Philadelphia, and he continued research on viral diseases of the skin as a member of the Research Department of that institution and as Assistant Professor of Dermatology, University of Pennsylvania. He has served as consultant to The Surgeon General and Quartermaster General, U.S. Army, and to the Institute for Nuclear Studies, Atomic Energy Commission; and as Associate Medical Director of Squibb Institute for Medical Research, and Research Associate in Dermatology, College of Physicians and Surgeons, Columbia University. He has written over 100 papers and two books concerning the field of dermatology and microbiology. He is the former Chief Editor of the *Archives of Dermatology* and Past President of the Society for Investigative Dermatology. He is Director of the Commission on Cutaneous Diseases of the Armed Forces Epidemiological Board, and Chairman of the Dermatology Training Grant Committee, National Institutes of Arthritis and Metabolic Diseases, National Institutes of Health, Public Health Service.

Dr. Blank will present his paper, "Recent Trends in Dermatologic Therapy," to the Dermatology and Pathology Joint Section Meeting at 2:40 P.M., Sunday, May 8.

## HERBERT Z. LUND, M.D.

Greensboro, North Carolina



HERBERT Z. LUND, M.D. of the Moses H. Cone Memorial Hospital, Greensboro, North Carolina, is a graduate of the University of Utah and the University of Pennsylvania Medical School. His postgraduate work was done at Geisinger Hospital, Danville, Pennsylvania; Philadelphia General Hospital and Jefferson Medical College, Philadelphia; and Harvard University, Boston. He has served as Pathologist in hospitals in Pennsylvania, Cleveland and Detroit. He is presently Pathologist at Moses Cone Hospital in Greensboro, and Visiting Professor of Pathology at the University of North Carolina School of Medicine, Chapel Hill, N.C.

Dr. Lund will present his paper, "Some Special Considerations of Metastasizing Skin Tumors," at the Dermatology and Pathology Joint Section Meeting on Sunday, May 8 at 3:35 P.M. A summary of Dr. Lund's paper follows:

It is often taught that squamous cell carcinoma of the skin, in contrast to basal cell carcinomas, are likely to metastasize. Actually, the ordinary squamous cell carcinoma arising in the sun-damaged skin is ordinarily only a locally aggressive lesion and metastases are rare (lesions of the lip are excluded in this study). The squamous cell carcinomas of odd etiology (x-rays, chronic ulcers, osteomyelitis sinuses, burns, scars, arsenical heratoses) are more dangerous.

Malignant melanomas are often detected in a pre-cancerous stage and in this stage the odds for cure are very good. A group of melanomas with metastasis is studied to see what features betray a dangerous lesion. These will be discussed.

## FREDERICK C. SWARTZ, M.D.

Lansing, Michigan



FREDERICK C. SWARTZ, M.D., Lansing, Michigan, is Chairman of the Committee on Aging of the American Medical Association's Council on Medical Service. He received his A.B. degree from Miami of Ohio and his M.D. degree from the Medical College, University of Cincinnati. He served his internship at Cincinnati General Hospital. He received a Fellowship in Medicine at the Mayo Clinic, Rochester, Minnesota, and is presently in private practice in Internal Medicine at Lansing.

Dr. Swartz's presentation will be given to the Symposium on Geriatrics at 3:00 P.M., Monday afternoon, May 9. A brief summary of "Osteoporosis," follows:

Osteoporosis "the most prevalent bone disease" presents an almost limitless field for discussion.

The basic explanation for the disease probably lies in an imbalance of the normally acting homeostatic mechanism designed to preserve the bony skeleton in the face of calcium and protein lack—hormonal imbalance and limited physical activity and poor posture.

Osteoporosis discussed with a backdrop of Geriatrics emphasizes its position in the group of chronic diseases and long-term care illnesses. The diseases for the most part represent the impact of long-acting traumatic factors, the accumulated effect is to produce changes which at first represent variation from normal and later avert disease.

Thus basically, treatment in the area of prevention would be concerned with these fundamental concepts that have to do with good health—normally good nutrition—physical exercise and improved posture.

## BAYARD CARTER, M.D.

Durham, North Carolina



BAYARD CARTER, M.D., Duke University Medical Center, Durham, North Carolina, graduated from the Honour School of Physiology of Oxford University, England, and received his medical degree from Johns Hopkins, Baltimore. Postgraduate work was done at Yale University, and before becoming Chairman of the OB-GYN Department at Duke, Dr. Carter was head of the OB-GYN Department at the University of Virginia. He is presently Professor of Obstetrics and Gynecology at Duke. He is a member of the American Association of Obstetricians and Gynecologists; the Society of Pelvic Surgeons; a Fellow of the American College of Obstetricians and Gynecologists, and a Director of the American Board of Obstetrics and Gynecology.

Dr. Carter will present his paper, "Anaerobic Infections in Gynecology and Obstetrics," to the Obstetrical



and Gynecological Section Meeting at 3:45 P.M., Monday, May 9.

Following is a summary of Dr. Carter's paper:

The anaerobic organisms in the generative tract of the female can cause serious diseases. These organisms

are recovered from patients during pregnancy, abortion and in the puerperal state. They also play a major role in pyometra, pelvic abscesses, etc. As a group they are poorly understood and accurate classification is difficult. This paper will attempt to delineate some of the problems they cause in Obstetric and Gynecologic patients.

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112TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA  
Columbus, Georgia, May 8-10, 1966

*For Information and Applications, Write to:*

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee  
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## GOLF

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## HOUSING

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Mrs. John A. Meier, Albany

## AUXILIARY LIAISON

E. M. Molnar, M.D., Columbus

## 1966 CALENDAR OF MEETINGS

### State

Postgraduate Courses sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.

January 12-March 30—Psychosomatic Medicine follow-up course (12 weekly evening sessions):

March 24-25—Trauma

December 7-May 12—Georgia Circuit Courses (six sessions, one day each month at six centers in Georgia).

March 15-19—Postgraduate Seminar in "Fundamentals of Otolaryngologic Allergy," sponsored by the University of Tennessee College of Medicine, Memphis, Tenn.

March 16-18—A Symposium on "Clinical Aspects of Renal-Endocrine Interactions," presented by the Department of Medicine, Emory University School of Medicine, Grady Hospital Auditorium, Atlanta, Ga.

April 1-2—Postgraduate Course, "Trauma to the Hand," sponsored by Emory University School of Medicine, Emory University Hospital, Atlanta.

April 4-8—39th Annual Spring Congress in Ophthalmology and Otolaryngology sponsored by The Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.

April 12—1966 Paramedical Personnel Symposia to be held simultaneously in the following ten Georgia cities: Albany, Atlanta, Augusta, Columbus, Dublin, Gainesville, Macon, Rome, Savannah, and Waycross. The Symposia are co-sponsored by the Georgia Heart Association, Georgia State League for Nursing, Georgia Society of Medical Technologists, Georgia Dietetic Association, and the Georgia State Nurses Association.

April 11-16—"Workshop in Radioisotope Scanning," Emory University School of Medicine, Atlanta.

April 13-16—19th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Va.

April 14-16—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, Grand Bahama Hotel, Grand Bahama Island.

May 5-7—Ninth Biennial Cardiovascular Seminar, "Newer Methods in Ischemic Heart Disease," presented by the Section of Cardiology, University of Miami School of Medicine and the Heart Association of Greater Miami, Carillon Hotel, Miami Beach, Fla.

May 8-10—112th Annual Session of the Medical Association of Georgia, Columbus, Ga.

May 18-20—A Postgraduate Course, "Modern Physical Diagnosis of the Cardiovascular System," presented by the Department of Medicine, Emory University School of Medicine, Grady Hospital Auditorium, Atlanta.

### Regional

March 21-23—Dallas Southern Clinical Society, Statler-Hilton Hotel, Dallas, Tex.

### National

March 23-25—American Surgical Association, Boca Raton Hotel, Boca Raton, Fla.

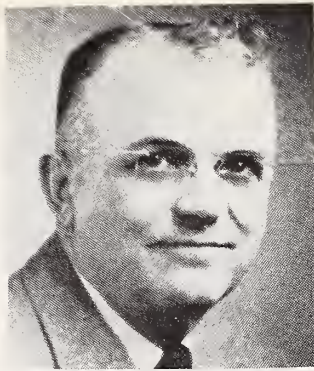
May 23-25—Annual Meeting of the American Thoracic Society, Medical Section of the National Tuberculosis Association, San Francisco, Calif.

June 26-30—American Medical Association Annual Convention, Chicago.

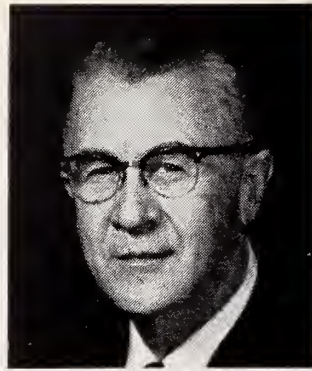




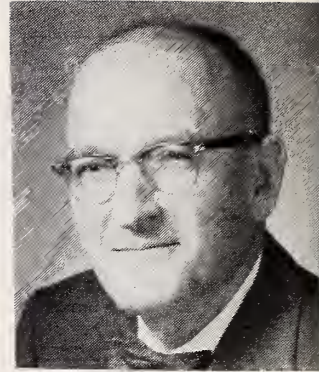
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First Vice President



**GEORGE ALEXANDER**  
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**WALTER BROWN**  
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**LAMAR P. PEACOCK**  
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#### Delegate

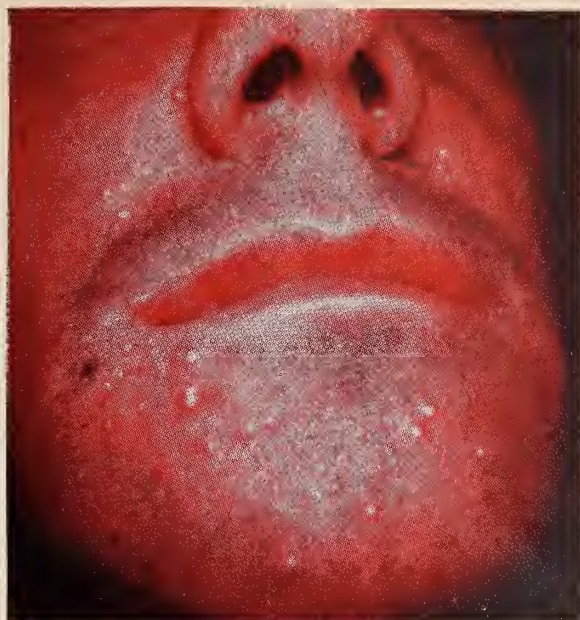
	<i>Term Ending</i>
J. W. Chambers, LaGrange . . . . .	(12-31-67)
J. Frank Walker, Atlanta . . . . .	(12-31-66)
Henry H. Tift, Macon . . . . .	(12-31-66)
Preston D. Ellington, Augusta . . . . .	(12-31-66)

#### Alternate

	<i>Term Ending</i>
T. A. Sappington, Thomaston . . . . .	(12-31-67)
John Kirk Train, Savannah . . . . .	(12-31-66)
John S. Atwater, Atlanta . . . . .	(12-31-66)
John T. Mauldin, Atlanta . . . . .	(12-31-66)



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rarely sensitizes

For the eradication of infectious organisms in a  
wide range of dermatologic disorders: impetigo,

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traumatic lesions, eczema, herpes and seborrheic  
dermatitis. Prophylactically, for protection against  
bacterial contamination in burns, skin grafts, inci-  
sions and other clean lesions, abrasions and minor  
cuts and wounds.

**Caution:** As with other antibiotic preparations, pro-  
longed use may result in overgrowth of nonsus-  
ceptible organisms and/or fungi. Appropriate  
measures should be taken if this occurs.

**Contraindication:** This product is contraindicated  
in those individuals who have shown hypersensi-  
tivity to any of its components.

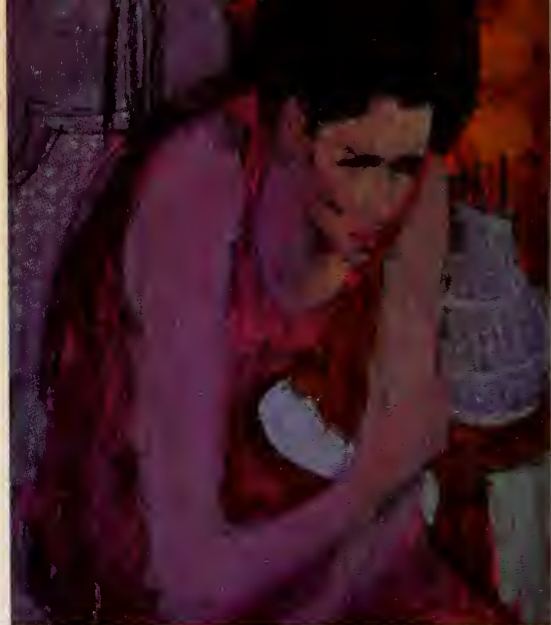
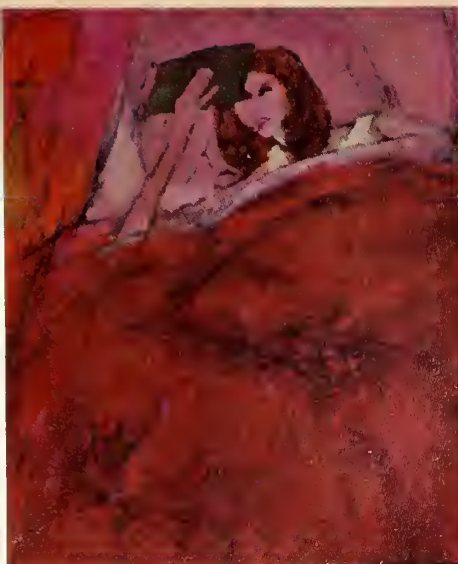
Complete literature available on request from  
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*chronic fatigue—lethargy*



*sistent insomnia*



*severe anorexia—weight loss*

*when  
emotionally  
based  
complaints fit  
the symptom  
profile of  
depression*



*recurrent G.I. upset*

**Clinical Considerations:** Contraindications—Glaucoma, urinary retention, bone marrow depression, pregnancy, drug-induced CNS depression. Precautions—The same dose for the two components, perphenazine and amitriptyline. Use carefully in patients with histories of convulsive disorders or adverse reactions to phenothiazines. ETRAFON potentiates effects of antidepressants, CNS depressants, atropine, phosphorous insecticides, and heat. The antiemetic effect of the perphenazine component may counteract the emetic effect of MAOI drugs. Consider the possibility of potentiation in combined use with MAOI drugs. Not recommended for use in children. **Warning:** Patients who become drowsy with ETRAFON should be cautioned against driving or operating machines requiring alert attention. Response to alcohol may be potentiated. **Side Effects**—Similar to those reported following the use of either component when used alone. For perphenazine alone, side effects caused by any of the phenothiazines may occur. These include extrapyramidal symptoms, autonomic reactions (including hypertension), blood dyscrasias, liver damage, endocrine disturbances, allergic reactions, peripheral and cerebral edema, reversed epinephrine effect, grand mal convulsions, polyphagia, reactivation of psychotic processes. For amitriptyline alone, drowsiness, hypotension, numbness and tingling of extremities, transient confusion (at high dosages), activation of latent schizophrenia (although perphenazine in ETRAFON may prevent this reaction in some cases). Dose-related anticholinergic reactions are possible. Rare appearance of agranulocytosis, jaundice, and peripheral neuropathy, all possibly of drug origin, have been reported in patients receiving amitriptyline. For complete details, consult Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07080. (1) Lehmann, H. E.: Psychosomatics 6:266, 1965. (2) Splitter, S. R.: Psychosomatics 6:322, 1965. (3) Smith and Incas, J.: Internat. J. Neuropsychiat. 1:220, 1965. (4) Coffee, F. M. A. Georgia 53:107, 1964. (5) Bowes, H. A.: Psychosomatics 5:44, 1964. (6) Pennington, V. M.: Combined Psychopharmacological Treatment of Depression, Scientific Exhibit, 18th A.M.A. Clinical Convention, Miami Beach, Nov. 29-Dec. 2, 1964. (7) Dorfman, W.: Psychosomatics 5:7, 1964. (8) Matthey, W.E.: Current Therap. Res. 5:310, 1964.



new  
Etrafon  
helps  
restore the  
appetite for  
life



When the patient's symptom pattern and the absence of physical findings confirm your suspicion of a depressive state, ETRAFON usually reverse the mental and functional slowdown—and allay the anxiety that accompanies depression. "...it is rare to find a depressed patient who does not also present definite symptoms of anxiety."<sup>1</sup>

**Prompt symptomatic response:** Somatic and emotional target symptoms are reported to respond promptly.<sup>2-4</sup> Insomnia, often the most important complaint in depression, is often first to be relieved.<sup>2</sup> (Bowes<sup>5</sup> found that the transient drowsiness sometimes caused by ETRAFON was generally beneficial to patients.)

ETRAFON offers the flexibility and convenience of 2 additional dosage strengths: (1) For more severe cases with predominant anxiety—ETRAFON-FORTE (amitriptyline HCl 25 mg. and perphenazine 4 mg.); (2) for adolescent or geriatric patients—ETRAFON-A (amitriptyline HCl 10 mg. and perphenazine 4 mg.). S-915

**More certain broad-spectrum relief:** ETRAFON is a broad-spectrum psychotherapeutic agent, capable of symptomatic relief not achieved with either drug alone in mixed emotional disorders. Pennington<sup>6</sup> states: "Since neurotic and psychotic anxiety and depression are simultaneously present in varying degrees, these two types of phrenotropic drugs in combination are more effective than either alone." Dorfman<sup>7</sup> and Coffee<sup>4</sup> report that patients unimproved on amitriptyline alone have responded to the combined therapy.

**Low incidence of side effects:** Matthey<sup>8</sup> reports that with ETRAFON "Side effects relatively few..." Another investigator states that side effects with amitriptyline-perphenazine combination are less than with each component alone. In Pennington's study of 428 patients, side reactions were less than half as frequent with ETRAFON with perphenazine alone, toxicity was low, and the absence of extrapyramidal symptoms was regarded as "...particularly noteworthy."<sup>6</sup>

# NEW ETRAFON

brand of antidepressant-tranquiliizer  
amitriptyline hydrochloride 25 mg. and perphenazine 2 mg.





**the sedentary life  
is often the seat of  
low back pain**

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

*The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ to relieve pain ☐ to relax muscles ☐ to restore mobility.*

**Indications:** 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

**Contraindications:** Allergic or idiosyncratic reactions to carisoprodol.

**Precautions:** 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

**Side Effects:** The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

**Dosage:** Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

**Supplied: Two Strengths:** 350 mg. white tablets and 250 mg. orange, two-piece capsules.

*Before prescribing, consult package circular.*

**for the relief  
of low back  
sprains and strains**

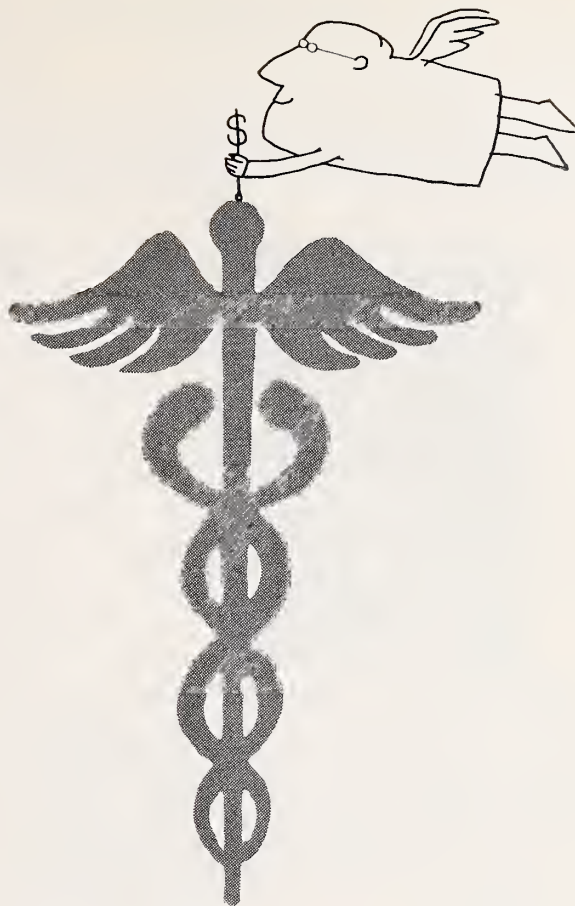
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# WOMAN'S AUXILIARY

to the

## MEDICAL ASSOCIATION OF GEORGIA

### 41st ANNUAL MEETING

Columbus, Georgia



#### PRESIDENT'S INVITATION

THE WOMAN'S AUXILIARY to the Medical Association of Georgia takes great pleasure in extending to you a cordial welcome to this convention. Plans have been made to make this meeting inspiring and exciting. Your presence at the meetings will be the reward for our efforts.

Mrs. Louie H. Griffin, Sr.  
President  
Woman's Auxiliary to the MAG



#### WELCOME TO COLUMBUS

TO EACH OF YOU comes a warm and sincere welcome to Columbus from the Woman's Auxiliary to the Muscogee County Medical Society. It is our hope that this, the 41st Annual Meeting of the Woman's Auxiliary to the Medical Association of Georgia, will be both pleasurable and meaningful to you all.

Mrs. George M. Hutto  
President, Woman's Auxiliary to the  
Muscogee County Medical Society

## THE PROGRAM

### SUNDAY, MAY 8

10:00 Registration and Information

to Lobby

3:30 Ralston Hotel

HOSPITALITY AND EXHIBITS, *Rooms*  
226-228

11:30 Pre-Convention Executive Board Meeting—Dutch Luncheon

to (Ball-Room, Ralston Hotel)

PRESIDING: MRS. LOUIE H. GRIFFIN, SR.,  
Claxton, *President*

INVOCATION: MRS. JOHN T. LESLIE,  
Avondale Estates

PLEDGE OF LOYALTY AND COLLECT:  
MRS. JOHN B. RABUN, Savannah

2:30 Heritage Tour

4:00 Tea—Honoring Past State Presidents  
Columbus Museum of Arts and Crafts

5:00 MAG General Business Session  
(Auditorium)

(All MAG and Auxiliary Members and  
Guests Invited)

PRESIDING: GEORGE ALEXANDER, M.D.,  
Forsyth, *President*

### MONDAY, MAY 9

8:30 Registration and Information

to Lobby

3:30 Ralston Hotel

HOSPITALITY AND EXHIBITS, *Rooms*  
226-228



**9:00 MAG General Business Session and House of Delegates Meeting (Auditorium)**

(All MAG and Auxiliary Members and Guests Invited)

**PRESIDING:** GEORGE ALEXANDER, M.D., Forsyth, *President*

**REPORT OF WOMAN'S AUXILIARY TO MAG:** MRS. JOHN A. MEIER, Albany, *President-Elect*

**9:00 Auxiliary General Meeting (Civic Room, Ralston Hotel)**

**CALL TO ORDER—**MRS. LOUIE H. GRIFFIN, SR., *President*

**INVOCATION—**DR. G. OTHELL HAND, Pastor, First Baptist Church, Columbus

**PLEDGE OF ALLEGIANCE AND COLLECT:** MRS. C. EMORY BOHLER, Brooklet, *President*, Bulloch-Candler-Evans Auxiliary

**ADDRESS OF WELCOME:** MRS. GEORGE M. HUTTO, Columbus, *President*, Muscogee County Auxiliary

**RESPONSE TO WELCOME:** MRS. FRANK McKEMIE, Albany, *President*, Dougherty County Auxiliary

**PRESENTATION OF CONVENTION PLANS—**MRS. ROBERT H. CARPENTER, Columbus

**INTRODUCTION OF PAGES FOR THE DAY—**MRS. JOHN G. DURDEN, Columbus

**REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY**  
DR. T. A. PETERSON, *Chairman*, Savannah

**Greetings**

**PRESIDENT OF MAG—**GEORGE ALEXANDER, M.D., Forsyth

**PRESIDENT-ELECT OF MAG—**WALTER BROWN, M.D., Savannah

**INTRODUCTION OF PAST PRESIDENTS AND GUESTS—**MRS. LUTHER H. WOLFF, Columbus

**INTRODUCTION OF GUEST SPEAKER**  
MRS. JOHN L. ELLIOTT, Savannah

**ADDRESS:** MRS. JOHN M. CHENAULT, Decatur, Alabama, *Director*, Woman's Auxiliary to American Medical Association

**Business Session**

(All reports limited to two minutes)

**CONVENTION RULES OF ORDER—**  
MRS. LEO SMITH, Waycross, *Parliamentarian*

**ROLL CALL AND MINUTES—**  
MRS. JULIUS T. JOHNSTON, Augusta, *Recording Secretary*

**REPORTS—**

*President:* MRS. LOUIE H. GRIFFIN, SR.

*President-Elect:* MRS. JOHN A. MEIER

*Treasurer* (Including Auditor's Report):  
MRS. C. JAMES ROPER, Jasper

**ADDENDUM REPORTS—**

(Complete Reports are published in the 1965-1966 Annual Report Book.)

**RECOMMENDATIONS FROM THE EXECUTIVE BOARD**

**REPORT OF THE REVISIONS COMMITTEE—**MRS. WILLIAM WILKES, Augusta, *Chairman*

**REPORT OF CREDENTIALS COMMITTEE—**MRS. WILLIAM C. COOK, Columbus

**ANNOUNCEMENTS**

**11:30 RECESS OF SESSION**

**12:00 GaMPAC—Auxiliary Members and Guests Invited**

**1:00 Luncheon and Fashion Show—The Harmony Club**

**PRESIDING—**MRS. LOUIE H. GRIFFIN, SR.

**INVOCATION—**MRS. WALKER L. CURTIS, College Park

**TUESDAY, MAY 10**

**9:00 MAG General Business Session and House of Delegates Second Meeting**  
(All MAG and Auxiliary Members and Guests Invited)

**8:30 Registration and Information to Lobby**

**11:30 Ralston Hotel**

**HOSPITALITY AND EXHIBITS, Rooms 226-228**

**9:00 General Meeting—Continued (Civic Room)**

**CALL TO ORDER—**  
MRS. LOUIE H. GRIFFIN, SR.

**IN MEMORIAM—**MRS. BRUCE THREATTE, Columbus

**INTRODUCTION OF PAGES FOR THE DAY—**MRS. JOHN DURDEN, Columbus

**ANNOUNCEMENTS**

**Business Session**

**MINUTES—**MRS. JULIUS T. JOHNSON, Recording Secretary, Augusta

**REPORT OF REVISIONS COMMITTEE—**  
MRS. WILLIAM A. WILKES, Augusta

**REPORT OF BUDGET AND FINANCE COMMITTEE—**

MRS. WILLIAM D. PENDERGRAST, Atlanta

**REPORT OF THE RESOLUTIONS COMMITTEE—**MRS. NEAL F. YEOMANS, Waycross

**REPORT OF CREDENTIALS COMMITTEE—**MRS. HARRY BRILL, Columbus

**REPORT OF THE COURTESY COMMITTEE—**MRS. WILLIAM W. ORR, Macon

**REPORT OF AWARDS COMMITTEES:**  
**Achievement—**MRS. FLOYD R. SANDERS, JR., Decatur

**Disaster Preparedness—**MRS. CARL S. PITTMAN, JR., Tifton



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GOLDSMITH, Albany  
James N. Brawner, M.D. Trophy of Gen-  
eral Excellence—MRS. JOHN T. LESLIE,  
Avondale Estates

REPORT OF THE NOMINATING COM-  
MITTEE—MRS. JOHN T. LESLIE, *Chair-  
man*

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS—  
MRS. W. P. RHYNE, Albany

PRESENTATION OF PRESIDENT'S PIN  
AND GAVEL—MRS. LOUIE H. GRIFFIN,  
Sr., Claxton (Retiring President)

INAUGURAL ADDRESS AND  
ANNOUNCEMENTS OF 1966-67

CHAIRMANSHIPS—  
MRS. JOHN A. MEIER, Albany  
PRESENTATION OF PAST PRESIDENT'S  
PIN—MRS. JOHN T. LESLIE, Avondale  
Estates

ANNOUNCEMENTS

11:30 Adjournment

12:00 Post Convention Executive Board Meet-  
ing—Dutch Luncheon  
(Green and Gold Room)

PRESIDING—MRS. JOHN A. MEIER,  
Albany, *President*

12:30 Past President's Luncheon (Dutch)  
Christian Fellowship Association  
1240 Wynnton Road

(For Past Presidents of Woman's Auxiliary  
to MAG)

PRESIDING—MRS. JOHN T. LESLIE, Avon-  
dale Estates, *Immediate Past President*

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"Keep us, O God, from pettiness; let us be large in thought, word and deed. Let us be done with faultfinding, and leave off self-seeking. May we put away pretense, and meet each other face to face, without self-pity and without prejudice.

May we never be hasty in judgment, and always generous. Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid. Grant that we may realize it is the little things that create differences; but in the big things of life we are one.

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Women are manifesting an increased interest in medicine by increasing their numbers as both medical school applicants and as medical school graduates. With the growing shortages of medical personnel and the increasing roles in medicine compatible with the accepted roles imposed on women by our culture, even greater numbers of women may in the future consider medicine as a career.

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Presenting data on men and women medical school applicants and acceptances shows a slow but steady increase in the number of women making application to and being accepted by U.S. medical schools in the years 1929-30 to 1964-65. In this time period the proportion of women in the accepted group has grown from 4.5% to 9.1%.

A true measure of the success of a group of students must follow their medical school progress from the time they enter medical school to such time as they leave it either as graduates or dropouts.

In comparing the medical school progress made by women with that made by men, it is apparent that a higher percentage of enrolled males completed their medical education. Of all students entering medical school in the ten year period from 1949 to 1958 91% of the men and 84% of the women ultimately received the M.D. degree. There are, however, differences between the groups in the reason for leaving school. The majority of men who drop out do so because of academic problems. Slightly more than half of the women leaving medical school do so for reasons other than academic difficulty.



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# KETOTIC HYPOGLYCEMIA

Eugene C. Jarrett, M.D.

Gerald H. Holman, M.D., *Augusta*

## ■ Report of one case with review of literature.

**H**YPOGLYCEMIA should always be considered in the differential diagnosis of convulsions of children. In fact, McQuarrie and Ulstrom<sup>1</sup> have stated that hypoglycemia, exclusive of that transiently seen in some newborn infants, occurs with more frequency than diabetes in infants and children below school age. Recently, a new form of hypoglycemia, in which ketosis is a major feature, has been described by Colle and Ulstrom.<sup>2</sup> The purpose of this article is to call attention to this problem of ketotic hypoglycemia with a case presentation and a brief review of the literature.

### To Recognize

Hypoglycemia may be due to easily recognized causes or to more obscure reasons. In 1924, Ross and Josephs<sup>3, 4, 5</sup> described a group of children with recurrent hypoglycemia, convulsions, and ketosis after a short period of fast. They noted that some of these children, who were being studied because of recurrent vomiting, frequently had convulsions between the hours of five to six a.m.

Elias and Turner,<sup>6</sup> in 1932, described four children who presented with shock secondary to low blood sugar. Three of these children responded to intravenous glucose. These children had acetonuria associated with their hypoglycemia. In 1934, a case was described of hepatogenic hypoglycemia secondary to lack of glycogen in the liver and failure of adrenaline response.<sup>7</sup> Rector and Jennings,<sup>8</sup> in 1937, described 11 patients with idiopathic hypoglycemia seizures. They mention that the onset of difficulty in these patients was between one and three years of age. Also in 1937, Hartmann and Jaudon<sup>9</sup> described one child with hypoglycemia and acetonuria in their review of hypoglycemic problems.

McQuarrie, Ulstrom, and Zeigler<sup>1</sup> described idiopathic familial infantile hypoglycemia and several other hypoglycemic entities in 1954. They stated that

the idiopathic condition is characterized by onset usually at an age less than two years, and that there are usually no physical stigmata. All of their patients had normal pituitary, adrenal, liver, and thyroid function. There was, at times, a familial tendency, and the children tended to recover with increasing age. No cause was found for the problem. Conn and Seltzer<sup>10</sup> described this condition in their review in 1955. Cochrane, et al.<sup>11</sup> described a case of hypoglycemia secondary to leucine sensitivity in 1956. Since this time DiGeorge and Auerbach<sup>12</sup> have reviewed this problem, and Thornton and Behal<sup>13</sup> have presented a case in which they showed that the amino acid caused a rise in insulin or insulin-like activity as soon as 30 minutes after the oral ingestion of leucine. In 1959, Broberger, Junger, and Zetterstrom<sup>14</sup> described idiopathic hypoglycemia in children who had little or no epinephrine response after insulin induced hypoglycemia. Haworth and Coodin<sup>15</sup> described a child with ketonuria and hypoglycemia in the morning, and also one with no urinary catecholamine response to hypoglycemia in their series studied and reported in 1960. Colle and Ulstrom,<sup>2</sup> in 1964, described a series of eight patients with ketosis associated with hypoglycemia after a short period of fasting. Defoe and Ulstrom<sup>16</sup> have noted that six children with ketotic hypoglycemia failed to increase epinephrine production prior to or in response to hypoglycemia. They felt that this failure to respond illustrated a combined storage depletion and defect in catecholamine production.

### Methods

Blood sugar determinations were made using the method of Folin-Wu.<sup>17</sup> Pituitary-adrenal relationship was tested by giving metapyrone (SU 4885), 30 mgm. per kg. per dose, every four hours for six doses and determining urinary steroid excretion using the method of Drechter, et al.<sup>18</sup> with some modifications. Non-esterified fatty acids were determined using

This study was supported in part by U.S. Public Health Service Research Grants AM 05538 and HD 01483.



SPECIAL CARBOHYDRATE STUDIES  
Total Reducing Sugars in mg. %

Time in Minutes	Fasting Test Prolonged	Glucagon Response After Prolonged Fast	Glucagon Response After 8 Hour Fast	Leucine Tolerance Test	Insulin Tolerance Test	Epinephrine Response (Febrile and Ketonuric)
0	—	25*	83	139	79	127
15	—	28	118	149	62	147
30	—	25	158	136	26	165
45	—	—	—	104	85**	—
60	—	25	192	104	54	153
90	—	—	—	—	64	—
16 hrs.	75	—	—	—	—	—
20 hrs.	25	—	—	—	—	—

\* This test was begun after 20 hours of prolonged fasting.  
\*\* This value is thought to be due to a laboratory error.

the method of Dole.<sup>19</sup> For the insulin tolerance test, 0.1 U of insulin was given. To check catecholamine production during and after the insulin tolerance test, urinary VMA\* levels were assayed using the method of Sunderman, et al.<sup>20</sup> Leucine was given orally, 150 mgm. per kg., for the leucine tolerance test.

### Case Presentation

This three-year, one-month old white male was born by caesarian section because of placenta previa with a birth weight of 2,100 grams, length of 45 cm., head circumference 29.5 cm. and chest circumference of 27 cm. He had no difficulty until the second day of life when he had a seizure which was treated successfully with calcium gluconate. His development was uneventful until seven months of age when he developed a high fever and a rash. The family was told that he had roseola. He had frequent colds but no seizures until he was 16 months of age when he was found one morning in bed with his eyes "waving back and forth," and he was unresponsive. He was treated with "shots." He was in good health until 34 months of age when he was again found in bed in the morning, unresponsive, with his eyes fixed. He was picked up and said that he wanted to go to the bathroom. He was taken there, vomited, collapsed, and cried out several times. No spinal puncture was performed with either seizure, but his blood sugar was 25 mg. % after the last seizure. He was treated with frequent feedings after the last episode and had no further seizures until he was seen in this hospital. Physical examination on admission here at 37 months of age revealed a blood pressure of 80/50, pulse 72 per minute, weight 24 kg., length 90 cm. (both below three percentile). The patient was a well-developed, well-nourished child in no distress. He was small for his age and had very little subcutaneous fat. The skin was warm with good turgor. Lymphatic examination was unremarkable. Examination of the eyes, ears, nose, and throat was unremarkable. The chest was symmetri-

cal, and the lungs were clear to percussion and auscultation. There was no cardiomegaly. The heart had a regular rhythm with no murmurs. There were no organs or masses palpable in the abdomen. Genitalia were normal. Extremities revealed no bone deformity. Neurological exam was normal.

### Studies Performed

Several special carbohydrate studies were performed (Table). The first test performed was a fasting test. After 16 hours of fasting (Figure 1) his blood sugar was 75 mg. %. After 20 hours he began having hallucinations and a blood sugar at this time was 25 mg. %. He was given 0.5 mg. glucagon intravenously and had no response in one hour. He continued to have occasional hallucinations and bizarre behavior with occasional generalized twitching during this hour. His behavior returned to normal immediately when he was given 50% glucose intravenously. Ketonuria occurred during this hypoglycemic period. After two days resting with a regular diet, he had a normal response to glucagon after an eight hour fast. The results of the insulin tolerance test are shown in Figure 2. His blood sugar fell to 26 mg. % at 30 minutes and he had a "wild-eyed" look which had been described previously by his parents. He had little or no sweating during

Fasting test begun at 4 P.M. on the previous day

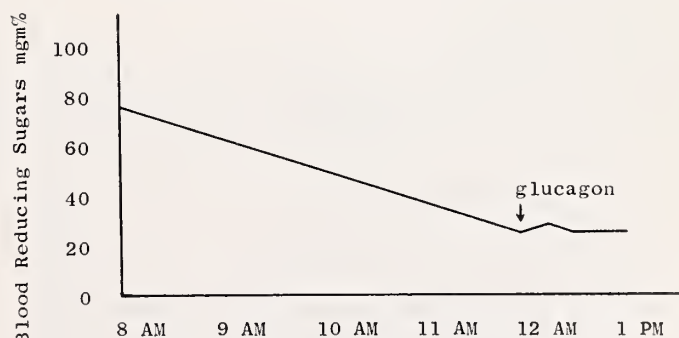


FIGURE 1

Report of one case with review of literature.

\* VMA—vinyl mandelic acid (3 hydroxy-4 methoxy mandelic acid).



this period of hypoglycemia, and his catecholamine output as measured by VMA excretions in urine was actually lower during the 12 hour period including the insulin tolerance test than during the 12 hours preceding the test. Non-esterified fatty acids at the beginning of the insulin tolerance test were 2,009, after 30 minutes 540, and at 90 minutes 1,008. No abnormal response was obtained when leucine was given orally. Pituitary-adrenal relationship was normal as measured by the metapyrone (SU 4885) test. He was given epinephrine after developing mild fever with ketonuria and had a normal blood sugar response. His osseous bone age was that of a two-year-old male. Serum proteins, hemogram, urinalysis, skull x-rays, and electroencephalogram were all normal.

### Discussion

Colle and Ulstrom<sup>2</sup> have described several characteristics present in their patients with "ketotic hypoglycemia." The attacks and convulsions are episodic in nature with the child being normal between the attacks. The first attack rarely occurs prior to 18 months of age. The attacks occur after a period of fasting, and acetonuria is present with the hypoglycemia. There is a prompt response to glucose. Fasting blood sugars are normal between attacks, and there is no hypoglycemic problem after glucose loading. The children are not leucine sensitive. They have a normal response to glucagon or epinephrine after a 12 hour fast, if they have been on a normal diet prior to the fast. This response indicates that they have glycogen stores present. The majority of the children are of normal intelligence and the attacks have decreased in frequency as the chil-

dren have grown older. The children are below the 50th percentile in height and weight, and they all have a diminished amount of subcutaneous fat.

### Characteristics Present

The patient in this report failed to increase catecholamine output in response to hypoglycemia as measured by his VMA excretion in the urine. Also during the insulin tolerance test, when his blood sugar was 26 mg. %, he had no definite clinical signs of epinephrine response (sweating, tachycardia). As mentioned, he had many of the characteristics mentioned by Colle and Ulstrom.<sup>2</sup>

This child has been successfully managed on a diet containing normal amounts of carbohydrates, fat, and protein. He is being given ephedrine daily to support his diminished, or absent catecholamine production. The parents check his urine for acetone at bedtime, and if it is positive, give him a bedtime snack. Since this regimen was started nine months ago, he has had no further convulsive episodes. His height and weight have remained below the third percentile, but he has a steady rate of growth as measured by height and weight.

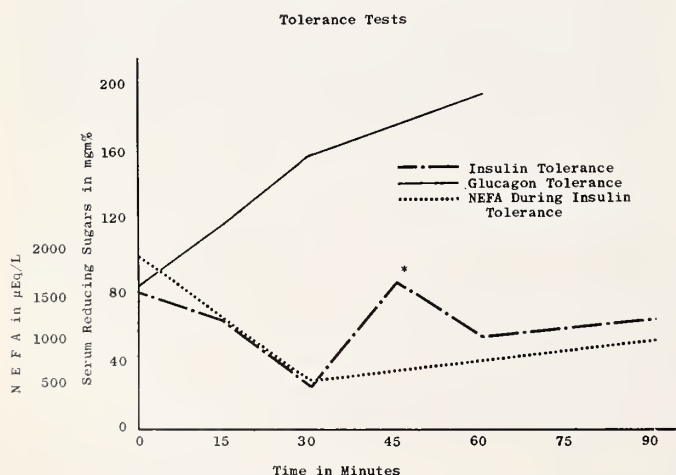
At three years ten months of age he was fasted while taking ephedrine, 20 mgm. daily. After ten hours he became "wild eyed and began shaking." His blood sugar at the onset of the fast was 143 mgm. % and was 53 mgm. % when he became symptomatic. He was given glucagon and had some clinical improvement but promptly returned to normal after receiving intravenous glucose solution. At no time during the fast did he develop ketonuria, which might indicate some protection by the ephedrine.

### Summary

A case of ketotic hypoglycemia with convulsions is presented with a brief review of the literature regarding hypoglycemia and more specifically ketotic hypoglycemia. Diagnostic criteria of this disorder are reviewed, and the management of this patient presented.

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VMA 12 hours prior to Insulin Tolerance - 7.68 μ/mgm creatinine  
12 hours including Insulin Tolerance - 5.8 μ/mgm creatinine

\* This value thought to be due to laboratory error

FIGURE 2

Report of one case with review of literature.



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Department of Pediatrics  
Medical College of Georgia

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## "THE MEDICAL UNITS 'PLANNING GUIDE'" AND "THE BUSINESS SIDE OF MEDICAL PRACTICE" AVAILABLE TO GEORGIA DOCTORS

For the third consecutive year, the Medical Association of Georgia is offering to the doctors of Georgia the American Medical Association-Sears, Roebuck Foundation, Inc. booklets entitled, "The Business Side of Medical Practice," and "The Medical Units 'Planning Guide.'" The material is free of charge and either or both may be obtained by writing to the *MAG Head-*

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Each booklet, constructed of heavy vellum stock, measures approximately 12" × 9" and contains charts, graphs, illustrations, floor plans, etc. Both are made for easy handling and make a nice addition to a doctor's office library.



# CONTROL OF THE PSYCHOGENIC FACTORS IN SKIN DISEASES

Glenn E. McCormick, M.D., *Decatur*

**A**LTHOUGH the physical causes of many dermatoses are still unknown or poorly understood, the capacity of the skin to reflect disturbances of the psyche has been realized since earliest recorded history.<sup>1</sup> Until the publications by Bunnemann in the 1920's,<sup>2, 3</sup> modern authors appear to have neglected the role of the psychogenic components in abnormal skin processes.<sup>4, 5</sup> Since that time, however, an immense literature has accumulated on the complex relationship of the emotions to the functioning of the nervous, circulatory and glandular elements of the skin.

## Emotional Aberrations

Dermatoses may originate in or be aggravated by emotional aberrations, although the response may be slower than those seen in other organs. Dyshidrosis long has been recognized as a sequel to mental stress. Acne vulgaris, although basically a somatic disturbance, may be prolonged by psychogenic stimuli.<sup>6, 7</sup> In light of the evidence concerning the control of the sebaceous glands by the nervous system, it is possible that such influences also may participate in the multiple etiology of seborrheic dermatitis. An obsessive-compulsive personality frequently characterizes the seborrheic patient. Although the underlying causes of psoriasis never have been definitely established, it is generally conceded that attacks may be initiated or prolonged by anxiety and tension.<sup>8</sup> Emotional factors also may be of etiologic importance in alopecia areata, urticaria, neurodermatitis and rosacea.

## Numerous Agents

Numerous agents designed to influence the emotions have been introduced in recent years, among them certain 1,4-benzodiazepine derivatives. One such substance, oxazepam\* (7-chloro-1,3-dihydro-3-hydroxy-5-phenyl-2H-1,4-benzodiazepine-2-one)<sup>9, 10</sup> demonstrated, in experimental studies, a low toxicity, and considerable flexibility of dosage without the attendant depression that characterizes other members of the series.<sup>11-13</sup>

## ■ A double blind study of sixty-eight dermatologic patients has yielded favorable results.

Animal experiments<sup>14</sup> on the metabolism of oxazepam indicated that the substance is the major metabolite of an earlier 1,4-benzodiazepine compound. These studies led to the conclusion<sup>14</sup> that the metabolic process entails but a simple biochemical transformation to glucuronide, which suggested a less varied pharmacologic activity for oxazepam, hence less liability to side effects than is true for the other members of the series.

The pharmacologic studies of Gluckman<sup>15</sup> supported this impression. The safety ratios established for oxazepam, by a variety of tests in a number of species, showed a wider spread between the minimal effective dose and the dose that causes side effects than could be demonstrated for the other benzodiazepine compounds studied.

## Ability of Substance

Sainz<sup>16</sup> has suggested that the influence of oxazepam on anxiety and tension in the human may be explained by the ability of the substance (a) to oppose discharge of epinephrine, from which the anxiety of stress arises; and (b) to inhibit release of norepinephrine, which produces true endogenous anxiety.

A number of clinical investigations have described the utility of the compound in various areas of psychopharmacology,<sup>17-24</sup> but none have been carried out in the realm of dermatology. A double blind, controlled study, therefore, was undertaken to determine the possible value of oxazepam for control of the psychogenic factors in skin diseases.

Sixty-eight white patients, predominantly female and principally young adults, were treated in private dermatologic practice for a variety of chronic skin disorders. All had received conventional treatment for various periods of time, but except in one case, their skin lesions had shown no improvement. All

\* Serax®; Wyeth Laboratories.



evinced some degree of distress concerning their lack of progress. At initiation of this study the total group presented an aggregate of 244 emotional symptoms, mainly tension, anxiety, irritability, agitation, insomnia and depression.

Administration of Coded Tablets

Medication was administered in coded tablets containing 10 mg. oxazepam, 10 mg. chlordiazepoxide, or placebo. All three lots of tablets appeared identical. The contents were unknown to the attending physician, nurses and patients throughout the study. When the code was broken it was found that the series formed three groups: 27 who were treated with oxazepam; 21 with chlordiazepoxide; and 20, with placebo. The dermatologic diagnoses are listed in Table I. One of the elderly patients in each group had hypertensive cardiovascular disease. A few had received prior medication for emotional stress.

In the blind treatment of the series, it so happened that 112 or 46%, of the total emotional symptoms occurred in the group who received oxazepam. In 41% of these patients the skin lesions were becoming worse. Only about half this percentage in the other two groups were in a similar unfavorable condition. (Table I.)

Dose

The daily dose of oxazepam ranged from 20 to 40 mg.; and of chlordiazepoxide, from 20 to 60 mg. The placebo-treated patients received two

to four capsules daily. (Table II.) Duration of treatment averaged, for each group, 20, 18 and 15 days, respectively. Fifty percent of the oxazepam-treated patients received the medication for at least 21 days, whereas 33% of those who received chlordiazepoxide and 15% of those who received placebo were treated for this length of time. Ten (37%) of the patients treated with oxazepam received no local or other medication, whereas all of those treated with chlordiazepoxide and most of those under placebo medication required concomitant dermatologic therapy. (Table II.)

At the close of the study, the response of each individual emotional symptom was scored as: 0, eliminated; 1, reduced from severe or moderate to mild degree, i.e., still present but not noticeable enough to disturb the daily routine; 2, slightly altered, i.e., persistent distress, troublesome enough to interfere with daily activities, which tended to fluctuate throughout the day; 3, no change. A response of 0 or 1 was considered satisfactory.

Results

In the oxazepam-treated group, 24 emotional symptoms (21%) were eliminated, with proportionate healing of the skin lesions. On the other hand, only two (3%) of the emotional symptoms seen in the chlordiazepoxide-treated group, and one (1%) of those in the placebo group subsided, with concomitant improvement of the skin. The response of the oxazepam-treated patients in this respect was significantly better than that of the other two groups.

TABLE I  
68 DERMATOLOGIC PATIENTS PRESENTING WITH EMOTIONAL SYMPTOMS

Agents	Number of Patients			
	Oxazepam	Chlordiazepoxide	Placebo	Total
Sex:				
Male	5	8	5	18 26%
Female	22	13	15	50 74%
Age yrs.:				
Range:	15-64	11-74	14-67	
Average	36	31	35	
Diagnosis:				
Dyshidrosis	9	7	3	19
Acne, excoriated	6	4	7	17
Dermatitis, seborrheic	4	2	7	13
Psoriasis	1	4	1	6
Alopecia, neurogenic	2	2	0	4
Urticaria, neurogenic	1	1	1	3
Neurodermatitis, excoriated	1	0	1	2
Dermatitis, atopic	1	0	0	1
Dermatitis, contact	1	0	0	1
Acne rosacea	1	0	0	1
Folliculitis, scalp	0	1	0	1
Total Patients	27	21	20	68
Prior anti-anxiety treatment:				
None	23	18	19	60
Meprobamate	2	0	0	2
Unknown agents	2	3	1	6
Pretreatment status:				
Improving	0	0	1 ( 5%)	1
Static	16 (59%)	16 (76%)	15 (75%)	47
Deteriorating	11 (41%)	5 (24%)	4 (20%)	20



SKIN DISEASES / McCormick

Both active compounds produced over-all results significantly superior to those from placebo (t-test,  $p = <.05$ ).

Irritability, anxiety, insomnia, tension, depression and lethargy, in that order, were most successfully modified by oxazepam.

Side Effects

Side effects developed in three patients who received 30 mg. chlordiazepoxide per day. Two suffering from dyshidrosis, who showed slight improvement, and a third, who had rosacea unimproved by treatment, experienced persistent daytime drowsiness, which necessitated discontinuance of medication after one week. One placebo-treated patient also had slight drowsiness.

One oxazepam-treated patient with dyshidrosis, whose skin lesions failed to improve, displayed moderate hyperkinetic symptoms; medication was discontinued in one week. Slight drowsiness occurred in two patients who had dyshidrosis that improved slightly. Treatment was discontinued in one week. Another, who had seborrheic dermatitis and who was largely relieved of symptoms, was somnolent only in the evening and found this desirable. Daily doses of oxazepam for these patients ranged from 30 to 40 mg.

Summary

Sixty-eight patients were treated in private dermatologic practice for an aggregate of 244 emotional symptoms, principally tension, anxiety, irritability,

agitation, insomnia and depression, which accompanied various chronic skin diseases. Under the double blind technic, 27 patients were treated with oxazepam, in daily doses of 20 to 40 mg.; 21, with chlordiazepoxide, in daily doses of 20 to 60 mg.; and 20, with placebo. Duration of treatment averaged 20, 18 and 15 days, respectively. Fifty percent of the oxazepam-treated patients remained under medication at least 21 days versus 33% of those treated with chlordiazepoxide and 15% of those with placebo.

The oxazepam-treated patients exhibited 46% of the total symptoms (about twice the symptoms in the other two groups) and the greatest incidence of deterioration in skin lesions (41%). Twenty-one percent of the emotional symptoms were eliminated in this group, with proportionate improvement in the skin. This result was significantly superior to the symptom control shown by the other two groups—3% for the chlordiazepoxide-treated, and 1% for the placebo-treated patients (t-test,  $p = <.05$ ). Both actively treated groups exhibited results significantly superior to those for placebo (t-test,  $p = <.05$ ). Thirty-seven percent of those treated with oxazepam received no other medication, whereas all of those receiving chlordiazepoxide and most of those receiving placebo required concomitant dermatologic therapy.

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TABLE II  
MEDICATION FOR 68 DERMATOLOGIC PATIENTS

Agent	Number of Patients		
	Oxazepam	Chlordiazepoxide	Placebo
Initial total daily dose mg., or capsules:			
20, or 2	3	5	2
30, or 3	15	16	11
40, or 4	9	0	7
Initial dose unchanged	23	20	19
Dosage increased from			
20 to 30 mg.	1	0	0
20 to 40 mg.	2	0	1
30 to 40 mg.	1	0	0
30 to 60 mg.	0	1	0
Duration of treatment:			
Range, days	7-60	7-30	10-36
Average, days	20	18	15
Treatment for at least 21 days	50%	33%	15%
Total dosage, mg.			
Range	210 mg.-1.8 Gm.	140 mg.-1.11 Gm.	
Average	690 mg.	512 mg.	
Concomitant treatment:			
None	10	0	3
Topical	8	11	13
Topical with steroids	5	6	4
Topical, steroids & antibiotics	1	2	0
Steroids alone	2	1	0
Antihistamine	1	1	0



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*DeKalb Medical Building*

## FEBRUARY COUNTY SOCIETY LEADERSHIP CONFERENCE HIGHLIGHTS MEDICARE, MEDICAL ETHICS, SOCIETY ACTIVITY

The eighth Annual Medical Association of Georgia's County Society Leadership Conference was held February 5-6, 1966, at the Mariott Motor Hotel, Atlanta.

Opening the Conference on Saturday afternoon was a panel discussion on, "What Is Government Doing With Me?," a résumé of the latest information on the new Medicare law. Linton Bishop, M.D. of Atlanta was Moderator, and the panelists and their topics included Mr. James Murray, Regional Assistant Commissioner, Social Security Administration, Atlanta, who presented an "over-all" picture of what the new Medicare law is. John H. Venable, M.D., Director, State Department of Public Health, Atlanta, presented standards and criteria for hospitals and nursing homes under the Medicare law; and Mr. Douglass Richard, Atlanta, Bureau of Health Insurance, Social Security Administration, spoke on "Responsibilities of the Carrier" under the Supplementary Medicare Insurance program.

### Available Services

Highlighting the services available to the doctor through his various professional organizations was Frank Walker, M.D., Atlanta, who spoke on, "What Is the AMA and the MAG Doing for Me?" Speaking on Effective Organizational Activity was Mr. William R. Bowdoin, Vice Chairman, Board of Trustees, Trust Company of Georgia, Atlanta, and Chairman of the

Governor's Commission on Efficiency and Improvement in Government.

Sunday's Session opened with a panel discussion of five cases on medical ethics. Peter Hydrick, M.D. of College Park, Chairman of the MAG Medical Ethics Committee, served as Moderator for a panel composed of J. G. McDaniel, M.D., Atlanta; Charles Cowart, M.D., LaGrange; Don Schmidt, M.D., Cedartown; Joseph Griffith, M.D., Marietta; and J. Watts Lipscomb, M.D., Forest Park.

### Four Phases

"Projects Requiring County Medical Society Activity," was divided into four phases. Dr. Napier Burson, Atlanta, spoke on, "Areawide Hospital and Health Planning"; Dr. J. Gordon Barrow, Atlanta, on "Hospitalization Review"; Dr. W. D. Stribling, Gainesville, on, "Mental Health Community Programs"; and Dr. John McCain, Atlanta, reviewed the, "MAG 'Fee Schedule Negotiating Committee' Report."

Donald E. Wood, M.D., Indianapolis, Indiana, a member of the American Medical Association Political Action Committee's (AMPAC) Board of Directors, highlighted the close of the conference. Dr. Wood's topic was, "What PAC Can Do for You and the Profession—Why You Need AMPAC/GaMPAC and How It All Works."



# THE NEED FOR INTERAGENCY AND INTERDISCIPLINARY COOPERATION AS STATE MENTAL HEALTH PROGRAMS DEVELOP

Addison M. Duval, M.D.,\* *Atlanta*

**E**DITOR'S NOTE: *This paper, presented at the Annual Psychiatric Institute of the Medical College of South Carolina on April 2-3, 1965, seems to clearly express the thinking of Dr. Addison M. Duval and the State of Georgia Department of Public Health as to future directions in the planning of Georgia's Mental Health Program.*

In no time in history have the states had a better chance to improve the treatment and rehabilitation of the mentally disabled than now. At least two major reasons for this are apparent. Primarily, scientific research has provided the best treatment ever developed, together with ways of reducing the disabling results of disease. Secondly, the present social and political climate in the states is conducive to citizen understanding of mental disability. This results in a willingness to support corrective programs financially. In addition, the President and the Congress now appear motivated to actively support the development of state operated programs with federal funds on a sharing basis. Some conservatives have objected to such federal support on the basis that it may promote socialized medicine. I believe comprehensive community health care services can be provided under government sponsorship—local, state and federal—*without* interference with the private practice of medicine. In fact only *with* the help and support of organized medicine can these services be developed.

## Health Case Services

You will note that I have used the expression health care services rather than medical care services or public health services. I think this term is preferable for several reasons. Medical care services commonly refer to those services supervised, directed or delivered by physicians and nurses. Yet it is

abundantly clear that many necessary health services are also given by others such as rehabilitation workers, psychologists, social workers, ministers, school counsellors and other ancillary therapists. This is not only true with relation to mental disabilities but also with relation to physical disabilities such as polio, cerebral palsy, the aphasias, blindness, deafness and paralysis.

## Principles of Prevention

Unfortunately, the term public health has often carried with it the impression that it includes only services to the indigent. Strictly speaking, this is not true, for public health is built on the principles of primary, secondary and tertiary prevention. Primary prevention means preventing what can be prevented. Secondary prevention means treating what can be treated. Tertiary prevention means reducing disability caused by disease. These basic principles are just as applicable in the mental field as in the physical field. It is obvious that these public health principles apply to programs relating to the health of all the people and not just to the indigent, as some would have us believe. However, because of this variance in understanding, it would seem preferable to begin talking about community health rather than public health as Mattison has suggested in a recent article entitled "Public Health and Medical Care."<sup>1</sup> He suggests that community health be defined as the joint effort by use of official, voluntary and private resources to improve the health of all the people. This change in terminology might help to clarify our concepts and help eliminate confusion in this important health field.

I have chosen this method of introducing our principal subjects of discussion—interdisciplinary and interagency cooperation—because it gives me a

\* Director, Division of Mental Health, Georgia Department of Public Health.

<sup>1</sup> *Public Health and Medical Care*, Mattison. *Health News*, N.Y. State Department of Health, Vol. 41, No. 7, July '64.



sound foundation on which to build a series of ideas. So that you may know the personal frame of reference from which I speak, for 30 years of my professional career my full time was spent in treating the severely mentally ill and disabled on the one to one basis, namely, physician to patient. Suddenly, because of a second career, I found myself in an entirely new field—that of developing state programs where the emphasis was on service to groups and communities rather than to individuals. This new health effort seemed to me to require the services of many persons from many different disciplines who are working in many different agencies. How to develop interdisciplinary and interagency cooperation became a matter of the greatest necessity and urgency! This seemed even more imperative in light of the massive changes which are occurring in the socioeconomic aspects of community living. I refer to population explosion, urbanization with its flight from the rural areas, the strain on educational methodology and the influence of social deprivation on the health and welfare of a part of our present civilization.

One of the first major problems encountered in planning a modern mental health program for Georgia was the need to develop mutual respect and understanding between physicians who were psychiatrists and physicians who were community health officers. The dichotomy between these two physician groups is more easily understood when the history of the two groups is examined.

### The Emphasis

The major emphasis recently given to the training and education of the psychiatrist has been the development of knowledge and skills in the treatment of the individual patient whether in individual therapy or in group therapy. Little emphasis has been given in psychiatry to prevention of illness or to promotion of better personal mental health. This lack of teaching emphasis also applies to the epidemiology of mental illness and to the training of psychiatrists in consultation service to community agencies. In the language of public health the psychiatrist places more emphasis on direct service to the individual mentally ill patient and meanwhile pays too little attention to the indirect services of consultation and education, prevention, and promotion of mental health.

On the other hand, the public health physician—while primarily trained to emphasize indirect services—up to now has given only lip service to his responsibility for direct services to the mentally ill and retarded as a part of his public health duties. Because of his lack of familiarity with the causes and specific treatment methods of the mentally ill, the public health officer tends naturally to be suspicious of the

psychiatrist as a fellow physician in whom he can place his full confidence. The public health officer appears able to accept the clinical psychologist and psychiatric social worker on his staff more easily than he can the psychiatrist. As non-physicians, such professionals do not seem to threaten him as much or to produce as much anxiety. The rejection of physician by physician is an unfortunate phenomenon which, however, can be reduced or eliminated by working through their mutual problems together, day by day.

### Underrated Skills

I think it is fair to say also that the psychiatrist has been guilty of underrating the training and skills of the public health physician. Some psychiatrists still think that public health physicians have as their principal responsibility sanitation, examination of milk and water, and sewage disposal. While public health physicians do deal with such problems, this part of their job is miniscule compared with their much greater responsibility for the prevention of illness, the treatment of illness, the rehabilitation of the ill and the promotion of better health for all the people in the local community.

In our experience, these difficulties in relationship between the public health physician and the psychiatrist gradually disappear as each comes to understand and respect the other's knowledge and skills in his special field. At such time the capability of each begins to complement the other to the benefit of all concerned. This result is all important to the development of comprehensive state mental health programs. I have said many times that no such program can be developed without the support of organized medicine. I am now ready to say that the easiest and most natural way to develop modern state programs is through a joining of hands of those from the mental health disciplines with those from the public health disciplines. I am also ready to say that *one cannot separate mental health from public health or community health any more than we can separate mind from body*. In psychiatry we believe we must look at the whole functioning person to find insightful understanding. So likewise must we look at total health to understand part-functions such as mental health, physical health or environmental health.

### Unfortunate Trend

For these reasons, I think it is unfortunate that there seems to have developed recently a trend toward the development of separate state departments of mental health. Sixteen states now use this plan. While I agree that organization is principally useful to serve function, I think the attitude, knowledge and skills of the organizational director are more im-



portant than the organizational form itself. I think we have already proven in Georgia that a separate department of mental health is *not* necessary for the development of an efficient comprehensive mental health program. In our Health Department, we have a Division of Mental Health, a Division of Physical Health, a Division of Epidemiology and a Division of Administrative Services. In my judgment, the key to the success of this plan is the Department Director. He can make the program by his attitude, interest and motivation toward the coordination and integration of the various elements of the total health program. He can also break the program through lack of these attributes. Fortunately, we have a Director who has the motivation and leadership ability to insure the success of this organizational arrangement.

### Comprehensive Community Programs

In Georgia, we are already planning the development of comprehensive community *health* programs and not just mental health programs. Thus, our mental health program—which in the past has lagged behind physical and environmental health programs—can now develop more rapidly through the use of already existing local public health personnel such as the 28 physician health directors and the 500 county public health nurses. If this manpower were not available to assist our scarce mental health personnel, and we had to await the training and assignment of special mental health staff only to community program development, our job would be ever so much more difficult and delays would be inevitable. We do not say ours is the only organizational pattern which can lead to success. We do say it is one way to success *without* the necessity of a separate department of mental health.

### Of Utmost Importance

Time does not permit extensive discussion of the relationships of psychiatry with other mental health disciplines such as clinical psychology, psychiatric social work, sociology, rehabilitation, clinical chaplaincy and psychiatric nursing or with other disciplines related to physical or environmental health. Suffice it to say that all these interdisciplinary relationships are of utmost importance and none can be avoided or overlooked. The areas of expertise are rapidly changing in each of these disciplines. Each discipline is assuming more responsibility and authority, thus impinging on those in the next hierarchy. New knowledge and new techniques in one field often have great importance in other associated fields. Only by moving forward together with full coopera-

tion in these various disciplines can eventual total success be attained.

Thus far we have only discussed interdisciplinary coordination. The second topic for discussion is the need for interagency cooperation in state mental health programs.

### The Term

You will note that I have used the term *mental health* programs rather than *mental illness* programs. I was tempted to further broaden the topic to include welfare, but decided against it, principally because the term public welfare—like public health—has come to refer most often to services to the poor, and here I am talking about the general welfare of *all* the people which is a much broader concept. In this general sense it is difficult to separate welfare from health or health from education. Each has to do with the growth and maturation of healthy, happy, and well-integrated persons making up a mature community. In the same way I have difficulty in considering a mental health program—with its emphasis on health rather than just illness—without bringing in additional functions of society performed by other agencies such as rehabilitation, corrections, the courts, probation and parole, the church, labor, urban renewal, and the voluntary agencies—to name only a few.

### A Specific Investment

Most of these agencies have a direct responsibility and a specific investment in mental health programs. Thus, while a primary mental health program staff may have major responsibility for the state's program, this should not relieve the other agencies from assuming their share of responsibility for their own part of the total program. In some instances it is advisable for the primary mental health staff to serve as consultants to other statewide agencies as they develop their own separate programs. Such a plan is frequently used by education, the courts, rehabilitation, maternal and child health, and pardon and parole. At the same time, the Department of Education might well be additionally responsible for the development of a school curriculum to include the teaching of mental hygiene and a service program of counselling and psychological evaluation of all students. The Department of Corrections would need to develop a mental health diagnostic, evaluation and treatment service for all its inmates. In some states, the state mental hospital furnishes consultant services at the correctional institution and treatment in the state hospital. In my opinion, it is usually better to establish all these services within the peripheral security of the corrections institution. This makes for a more self-contained and stable arrangement. In this plan there would be no need to provide a security



building at the state hospital with its accompanying anxieties to the hospital staff and the nearby host community. Also a more relaxed program can be operated within the security of the correctional institution. The greatest drawback to this plan is the difficulty in recruitment of competent professional staff, especially where the penal institution is located in an isolated rural area.

### Everyday Assistance

Probably the greatest contribution by agencies—other than health agencies—to the development of better community mental health is found in the everyday assistance given by staff to those troubled persons needing help. Not in the foreseeable future will there be enough professional mental health staff alone to do this massive job even if this were advisable. However, through inservice education and interagency cooperation, new knowledge can be disseminated to the people who serve in all the agencies, and through them, help be given to those in need. This idea of using all available community resources may seem utopian to the casual observer, but it certainly should be given a fair trial because of its enormous potential for good.

### The Greatest Challenge

In my judgment, one of the greatest challenges in state government today is how to develop full interagency cooperation. In truth, most agencies carry on their work without giving much thought to any program needs beyond their own rigid confines. Some agency directors may see each other only after long intervals of time, and then only casually. The cure of such lack of cooperation requires strong medicine. This medicine may best be administered by the Governor, who is in a strategic position to develop an official interagency mental health council—or health council—with himself as Chairman—if he so desires. Under this plan, the attendance of agency directors at council meetings would be assured. The Governor of Georgia has agreed to try out this plan, and we will watch its development with much interest. If the plan works, some of the headaches relating to lack of interagency cooperation may be cured, and if so, a new era of state program efficiency will be at hand.

### The Development

I would be remiss in this presentation if I limited my comments to the need for interagency and interdisciplinary cooperation and failed to offer some suggestions as to how such cooperation may be developed. Here no simple royal road to success is immediately apparent. Certain suggestions, however, may give us some clues as we call on our past experiences and look to the challenge of the future to find new solutions to expanding problems.

The following suggestions are intended only as guides. Each must be thoughtfully applied to the specific program under study and evaluation.

1. Goals and objectives must be constantly re-evaluated and refocused as needs change and new methods are developed.
2. Goals and objectives must be clearly outlined for single agency programs and for multi-agency programs as a prerequisite to cooperative effort.
3. Even though we may have a tendency to set up idealistic goals, we should force ourselves to set up realistic goals capable of attainment. Otherwise, interagency cooperation will be impossible.
4. Each agency must be clearly aware of the extent of role and function of every other agency participating in the cooperative effort.
5. Failure in keeping up communications is a major threat to cooperative effort. Solution of this problem is absolutely necessary to efficient operation.
6. Each agency and each discipline should be willing to commit itself to the development of a climate of tolerant understanding and to a flexibility of adjustment which at times may be painful. This may properly be referred to as the "golden rule" of cooperative public service.
7. Each agency and each discipline must respect the rights and prerogatives of the others. A constant willingness to compromise may spell the difference between success and failure. The broad view should take precedence over the narrow view.
8. Each agency and each discipline must clearly recognize its own limitations and imperfections and also be able to view without dismay the points at which multiple cooperative efforts reach a point of diminishing returns.
9. Each agency and each discipline should keep in mind the dignity and integrity of the individual to whom services are provided.
10. Our total helping efforts should primarily be aimed at helping the individual to help himself to strengthen his own resources and capacities toward independent responsible citizenship.

In the light of my own personal experience I have tried to bring you some thoughts about interagency and interdisciplinary cooperation as state mental health programs develop.



## MENTAL HEALTH PROGRAM / Duval

1. The timeliness of program development appears favorable for several reasons.
2. Health care services seems a better term than medical care services or public health programs in our changing conceptual framework. These services require the help of a great variety of people from different agencies and from different professional disciplines.
3. Some of the basic reasons for lack of understanding between agencies and disciplines have been outlined.
4. The separation of mental health from total health—both in theory and in practice—is deplored. Integration of community health services is as important as integration of the person needing such services. From my personal experience I cannot agree that it is always better—or even usually better—to establish a state department of mental health separated from other health programs. Where possible, I prefer to coordinate and unify all major state health programs in whatever type organization best fits the particular state's customs and mores and the available professional

staff to be involved in program development. No one model seems to fit the needs of all the states.

5. I subscribe to the public health principle of primary, secondary and tertiary prevention as applied also to mental health. This concept is useful and it should be more widely employed by members of the mental health professional disciplines and governmental agencies.
6. In conclusion, I have made certain suggestions which may be helpful in the development of improved interagency and interdisciplinary cooperation, as we move forward into a new and enlightened era of governmental services to the mentally disabled and to promotion of better mental health for all individuals.

To those of you who are dedicated to the improvement of mental health programs, the words of Marcus Aurelius are applicable—

"I expect to pass through this world but once; therefore, if there be any kindness I can show or any good thing I can do for any fellow being, let me do it now; let me not defer it or neglect it, for I shall not pass this way again."

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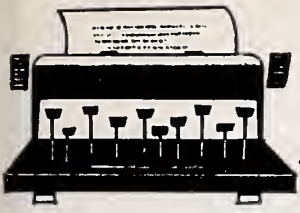
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## Welcome to Columbus Medical Association of Georgia—1966

ONCE AGAIN the time has come for the annual meeting of the Medical Association of Georgia to be held in Columbus. This privilege comes only every five years, and it is always with much pleasure that we look forward to opening our city and hearts to our fellow medical colleagues and their wives.

### Much Has Transpired

Much has transpired in this great free port city during the brief time since the last meeting was held here. The cultural and educational facilities have continued their explosive expansion, the Springer Opera House, of national fame, has been restored and is once again in use. We are especially proud of the progress of our Columbus College which is now granting a four-year degree. The Columbus Museum of Arts and Crafts continues to expand and houses the rare Yuchi Indian collection. A Confederate Naval Museum has been established. The gates of welcome swing open yearly for the "Heritage Tour of Columbus."

Industry continues to flourish and grow in this area. In the summer of 1963 the Chattahoochee River once again became navigable to the Gulf of Mexico, making Columbus Georgia's newest inland port city. Our manufacturing enterprises reach out internationally with a multiplicity of products which are well known to all of us.

Our metropolitan area has a reaching interest in surrounding counties with a population of nearly half a million, with the urban population of Columbus being 144,500.

We are proud of the new medical facilities that are being added daily and are especially proud of the new physicians who have selected this area in which to practice.

It is always with great pride that we speak of Fort Benning, the home of the Infantry and especially of the First Cavalry Division Airmobile which is maintaining our first line of defense in South Viet Nam.

Of special interest surrounding us are Andersonville National Cemetery, Ida Cason Callaway Gardens, Auburn University, Kolokomo Mounds, Lake Harden, the Little White House, Oliver Dam, Providence Canyons and many other sites of interest.

We are especially proud of our civic organizations, especially so of our public school system as well as our city and county governments. I could go on and on—Columbus is a good place in which to live and to visit. Columbus takes pride in its tradition for gracious hospitality. It is with great pride that we welcome you to Columbus.

*Louis A. Hazouri, M.D.  
President  
Muscogee County Medical Society  
Columbus, Georgia*

## Compulsory Laboratory Testing for Inheritable Defects

DURING the past few years, much interest has been generated concerning mental retardation.

Testing for one of the congenital metabolic disorders which may produce mental retardation—phenylketonuria—has been performed on over 400,000 newborns. The incidence of positive tests was (1:20,000) or possibly (1:10,000). A positive

test does not necessarily indicate the presence of disease. Positive tests require confirmation and verification by additional and different examinations.

Because of the possibility of preventing mental retardation, and the emotional impact of mentally retarded children upon many adults, sufficient concern has been expressed, leading several states to make



testing of newborns for phenylketonuria (PKU) compulsory.

In the first session of the 89th Congress, Senator Edward Kennedy introduced a bill designed to promote the detection of phenylketonuria and other in-born errors of metabolism which might produce mental retardation or physical defects. A bill to make PKU testing compulsory will likely be introduced in the Georgia legislature in 1966.

Compulsory testing for disease raises many questions. Presently, according to the Georgia Health Code, the only mandatory testing is the prenatal and premarital blood test for syphilis.

### Ramifications

The ramifications of such a law may extend to compulsory testing of adults for various diseases, particularly in view of the development of autoanalyzer techniques for automatically examining a small blood sample (2.5 cc. of serum) for as many as 12 tests in a few minutes with relatively little expense.

Another question raised concerns the number of tests which might be required in a newborn, in order to encompass the already known possible afflictions of humans, which would determine the various in-born errors of metabolism and chromosomal karyotypes. For example—homocystinuria is much more frequent than phenylketonuria, occurring in possibly 1:3000 infants tested. Other inheritable metabolic defects include maple syrup urine disease, porphyria, glycogenoses, lipoidosis, gargoylism, hypophosphatasia, atypical cholinesterase, non-spherocytic hemolytic anemias, hemoglobinopathies, dysproteinemias, transport diseases, endocrine disorders, and congenital hyperbilirubinemia.

Screening for amino acids by chromatographic studies is possible now and practically applicable to the usual medical laboratory. Tests for all diseases listed above are available and can be performed in most clinical laboratories. Such screening will increase, of course, the cost of medical care, a problem with increasing demands by the public for more and improved medical care.

### Considerable Cost

Chromosomal analysis is available in many sections of the country; however, the cost of a single analysis is considerable—in the range of \$100. There is an inadequate number of medical technologists to perform laboratory procedures now, and the demands

for paramedical personnel are increasing for the performance of all laboratory procedures.

Another question is that of the result of early detection and early treatment of these various diseases. Is the treatment effective, and should and do we have facilities and personnel available to manage individuals with these defects? When the defects are found early, is proper treatment effective in preventing mental retardation?

### Poor Genetic Material

A question which has been raised recently with more force has been that of the preservation and perpetuation of poor human genetic material.

Some congenital metabolic defects may not be manifest as mental retardation (an I.Q. below 70), yet be only slightly above this level and be perpetuated in a large number of offspring. It is possible that with the expanding knowledge of the biochemical enzymatic disorders, more elucidation will indicate that increasing numbers of mental disorders are metabolically initiated.

This poses the question of better genetic evaluation and eugenic practices in order to obviate the perpetuation of genetically unsound material. In order to find these individuals for genetic counseling, newborn or childhood testing would be needed.

### Will Problem Develop?

Although this may recall to mind the book, *Brave New World*, by Aldous Huxley, one must realize that what is done now will certainly be reflected in future generations. With expanding knowledge, the capabilities of fetology, and the detection of increasing numbers of congenital metabolic defects, a significant genetic problem may develop.

As indicated by Dr. William Shockley, co-winner of the 1956 Nobel Prize for Physics, an affluent society like that of America may be most in danger of producing deteriorating human beings.

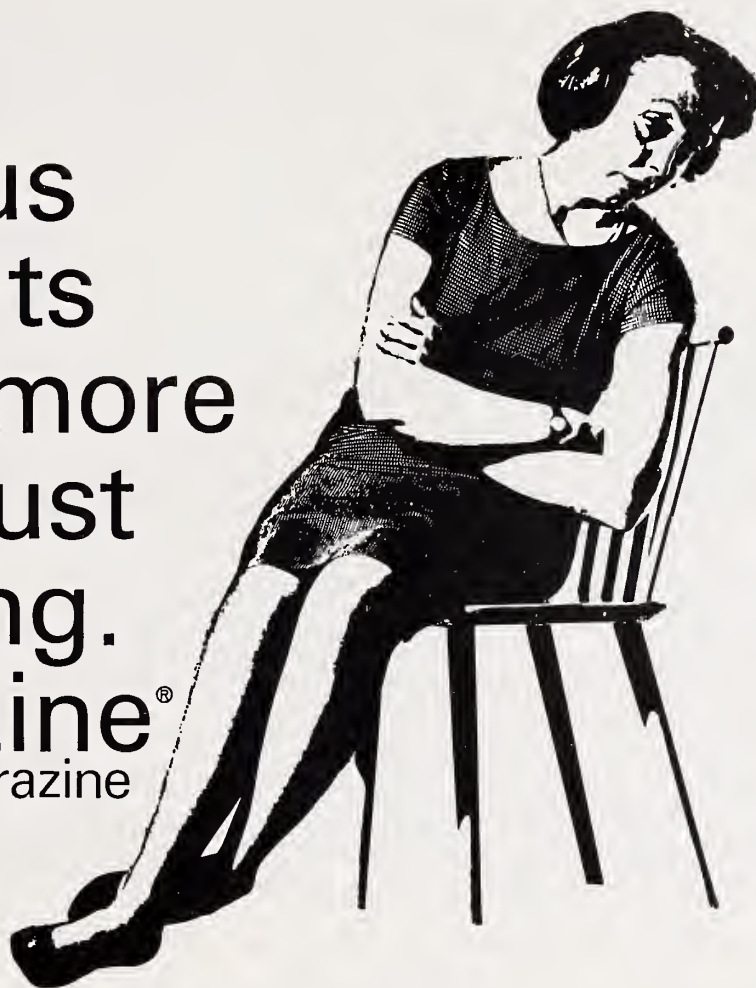
### Careful Study

It is evident that careful study of the general problems of inheritable defects should be accomplished, before compulsory testing for these defects is considered. Dissemination of information to physicians and recommendations about our present concepts and laboratory procedures concerning inheritable defects appear to be the logical step at this time.

John T. Godwin, M.D.  
St. Joseph's Infirmary  
Atlanta, Georgia



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## **FROM HEART DISEASE, CANCER AND STROKE TO CONTINUING MEDICAL EDUCATION**

**W**E ALL are aware that last Fall the medical profession had many misgivings concerning the heart disease, cancer and stroke legislation. You will remember that during the final phases of its passage, the special Advisory Committee of the American Medical Association working with Health, Education and Welfare officials was able to effect a number of changes in this bill.

The changes which were effected, while not making the program entirely to our liking, did make it less objectionable.

### **The Meaning in Georgia**

You may have been wondering just what this program might mean in Georgia. On January 12, the Medical Association of Georgia Board of Medical Education met at MAG Headquarters with Dr. Arthur Richardson of Emory and Dr. Harry O'Rear of the Medical College of Georgia. Out of this meeting came plans for a later meeting of the same group on January 23, along with representatives of the State Board of Health, the Communicable Disease Center and the applicable voluntary health organizations. Mr. Karl Yourdy of the National Institutes of Health was at this meeting to discuss the program and to answer questions.

It was brought out in the discussion that this can be a very flexible program and that "planning grants" can be obtained by a responsible agency or organization.

It was further brought out that a really desirable and worthwhile program of Continuing Medical Education might be developed.

Where does this leave us now? The consensus of this last meeting was that the two medical schools should cooperatively develop plans and make application for a planning grant in order that plans for a program might be developed. Following this, an application can then be made for funds to implement the program.

The Medical School Officials will be assisted by an Advisory Committee composed of representatives of the various organizations attending the January 23 meeting.

### **From Medical Education Board**

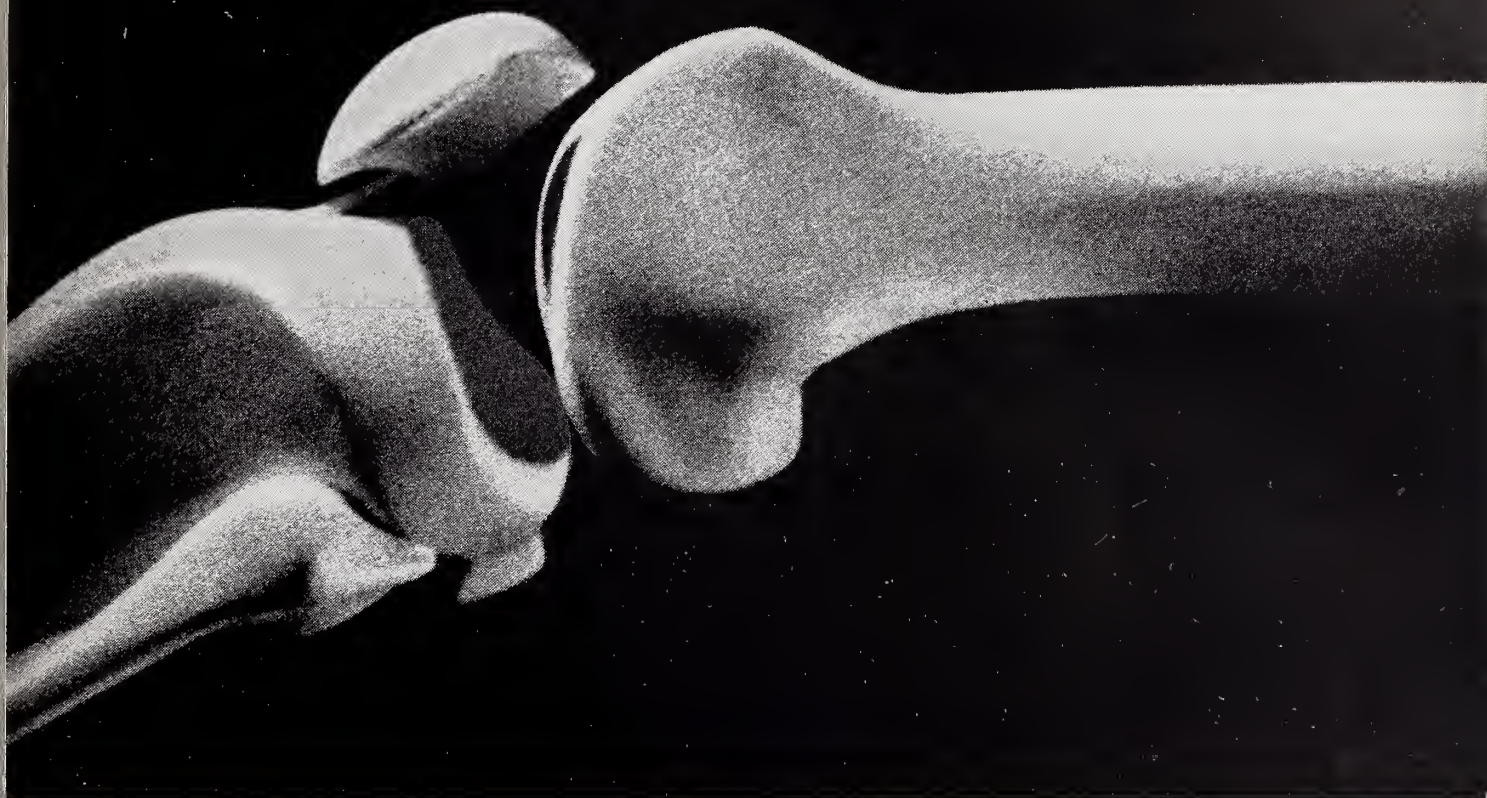
The MAG representatives will be drawn from the Board of Medical Education. Dr. Thomas W. Goodwin of Augusta, former MAG President and Chairman of the Board of Medical Education, has been named as MAG member of the Advisory Committee. Dr. T. A. Sappington of Thomaston, a member of the Board of Medical Education, has been named as alternate.

A meeting to include the Advisory Committee will be held in early February. Well before this sees print, I feel sure that an application for a "planning grant" will be "in the mill."

This, to me, makes very good sense and can mean much in the future to Continuing Medical Education in Georgia.

*George H. Alexander, M.D.  
President, Medical Association of Georgia*





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Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile, or when other potent drugs are given concurrently. Large doses are contraindicated in patients with glaucoma.

### Precautions

Obtain a detailed history and a complete physical and laboratory examination, includ-

ing a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

### Warning

If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

### Adverse Reactions

The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss

have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

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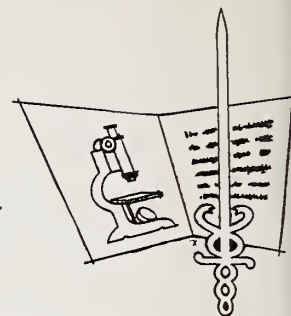


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## AMERICAN CANCER SOCIETY'S 1966 SCIENTIFIC SESSION

May 11, 1966—St. Francis Hotel—San Francisco, California

Morning Session—9:00 a.m.-1:00 p.m.

### INTRODUCTION

LEONARD W. LARSON, M.D.  
*President*  
*American Cancer Society*

LEWIS W. GUISS, M.D.  
*University of Southern California*  
*School of Medicine*  
*Los Angeles, California*  
*Chairman, Program Committee*

### UTERINE CANCER

*Chairman*

I. L. TILDEN, M.D.  
*Straub Clinic*  
*Honolulu, Hawaii*

*The Present Status of Cytology in Uterine Cancer*  
LEOPOLD G. KOSS, M.D.  
*Memorial Hospital for Cancer and Allied Diseases*  
*New York, New York*

*The Optimum Management of a Patient with a Positive Cervical Cytology Report*  
TOMMY N. EVANS, M.D.  
*Wayne State University School of Medicine*  
*Detroit, Michigan*

### COLON AND RECTAL CANCER

*Chairman*

JOHN G. WALSH, M.D.  
*Mercy Hospital*  
*Sacramento, California*

*Current Procedures in the Detection and Diagnosis of Colon and Rectal Cancer*  
H. MARVIN POLLARD, M.D.  
*The University of Michigan*  
*Medical Center*  
*Ann Arbor, Michigan*

*Modern Treatment of Colon and Rectal Cancer*  
WARREN H. COLE, M.D.  
*University of Illinois*  
*College of Medicine*  
*Chicago, Illinois*

*The Radiological Detection of Cancer and Polyps of the Colon and Rectum*  
WENDELL G. SCOTT, M.D.  
*Washington University*  
*School of Medicine*  
*St. Louis, Missouri*

### LUNG CANCER

*Chairman*

SOL R. BAKER, M.D.  
*University of California*  
*School of Medicine*  
*Los Angeles, California*

*The Control of Cigarette Smoking in the U.S.A.*  
THE HONORABLE MAURINE B. NEUBERGER  
*United States Senate*  
*Washington, D.C.*

*The Early Diagnosis of Lung Cancer*  
THOMAS CARLILE, M.D.  
*The Mason Clinic*  
*Seattle, Washington*

### BREAST CANCER

*Chairman*

JOHN M. DENNIS, M.D.  
*University of Maryland*  
*School of Medicine*  
*Baltimore, Maryland*

*Advances in the Early Diagnosis of Breast Cancer*  
THOMAS W. BOTSFORD, M.D.  
*Harvard Medical School*  
*Boston, Massachusetts*

*The Breast Cancer Treatment Controversy*  
ROBERT C. HICKEY, M.D.  
*University of Wisconsin*  
*Medical Center*  
*Madison, Wisconsin*

Afternoon Session—2:00 p.m.-4:30 p.m.

### ORAL CANCER

*Chairman*

B. L. ARONOFF, M.D.  
*The University of Texas*  
*Southwestern Medical School*  
*Dallas, Texas*

*Oral Lesions of Neoplastic Significance and Oral Cancer*  
SOL SILVERMAN, JR., D.D.S.  
*University of California*  
*School of Dentistry*  
*San Francisco, California*

*Management of Oropharyngeal Cancer*  
ARTHUR G. JAMES, M.D.  
*Ohio State University*  
*Medical Center*  
*Columbus, Ohio*



## SKIN CANCER

### Chairman

GLENN H. LEAK, M.D.  
University of Buffalo  
School of Medicine  
Buffalo, New York

### Early Recognition and Diagnosis of Skin Cancer

HERBERT L. TRAENKLE, M.D.  
University of Buffalo  
School of Medicine  
Buffalo, New York

### The Treatment of Skin Cancer

RICHARD H. JESSE, M.D.

M. D. Anderson Hospital  
and Tumor Institute  
Houston, Texas

## SPECIAL ADDRESS

### Premises and Prospects in Cancer Research

PAUL WEISS, Ph.D.  
The University of Texas  
Graduate School of Biomedical Sciences  
Houston, Texas

SESSIONS ARE OPEN TO ALL MEMBERS OF THE MEDICAL AND DENTAL PROFESSIONS AND STUDENTS. No advance registration or registration fee. Inquiries concerning this program should be addressed to: Director, Professional Education, American Cancer Society, Inc., 219 E. 42nd Street, New York, N.Y. 10017.

## DRUG ABUSE LAW EXPLAINED

On February 1, 1966, PL 89-74 went into effect. As has been widely publicized, its purpose is to curb drug abuse through the curtailment of illicit drug traffic. To accomplish this, the law establishes special controls over the manufacture and distribution of depressant and stimulant drugs. Among these controls is the keeping of records of the manufacture, sale, delivery, and receipt of such drugs, and it is to this matter of record-keeping, insofar as it refers to physicians, that I would like to invite your attention.

### The Records

Recently, there has been some confusion as to what records a physician must keep under PL 89-74. Putting it simply, *they are not required to keep records as a consequence of this law unless, in the course of their practice, they dispense the drugs referred to and charge for them.* The law is quite clear on this, and I quote from that part of the Act relating to record-keeping:

"The provisions of paragraphs (1, Records) and (2, Inspection) of this subsection shall not apply to a licensed practitioner . . . with respect to any depressant or stimulant drug received, prepared, processed, administered, or dispensed by him in the course of his professional practice, unless such practitioner regularly engaged in dispensing any such drug or drugs to his patients for which they are charged, either separately or together with charges for other professional services."

The key phrases in this paragraph are the words "regularly engaged" and "for which they are charged."

Further in this regard is a quote from the House Report of the Committee on Interstate and Foreign Commerce on H.R. 2 which became PL 89-74:

"The committee intends . . . to require record-

keeping and to permit inspection in the case of those physicians who maintained a supply of pharmaceuticals or medicinals in their offices from which they compound prescriptions for their patients for a fee."

The language of the Senate Committee Report is identical. Both committee reports stated that those required to keep records "involve only a very small percentage of physicians."

### Underscored Point

The proposed regulations underscore this point, indicating that ". . . maintaining of small supplies of these drugs for dispensing or administering in the course of professional practice in emergency or special situations will not be considered as regularly engaged in dispensing for a fee."

For those physicians who, in the course of their practice, *regularly dispense drugs and charge for them*, certain records are required to be kept for three years, effective February 1, 1966. Included are: a complete, accurate record of all depressant and stimulant drugs on hand February 1, 1966; a complete, accurate record of the kind and quantity of each drug received, sold, delivered or otherwise disposed of; the name, address (and registration number under Section 510 (e) of FDCA) of the person from whom the drugs were received, and to whom they were sold, delivered, dispensed or otherwise disposed of; and the date of the transaction. No separate form for these records will be required as long as the information specified is available.

Summing up, under PL 89-74 physicians do not have to keep records *unless* they regularly dispense the drugs covered by the Act and charge for them.

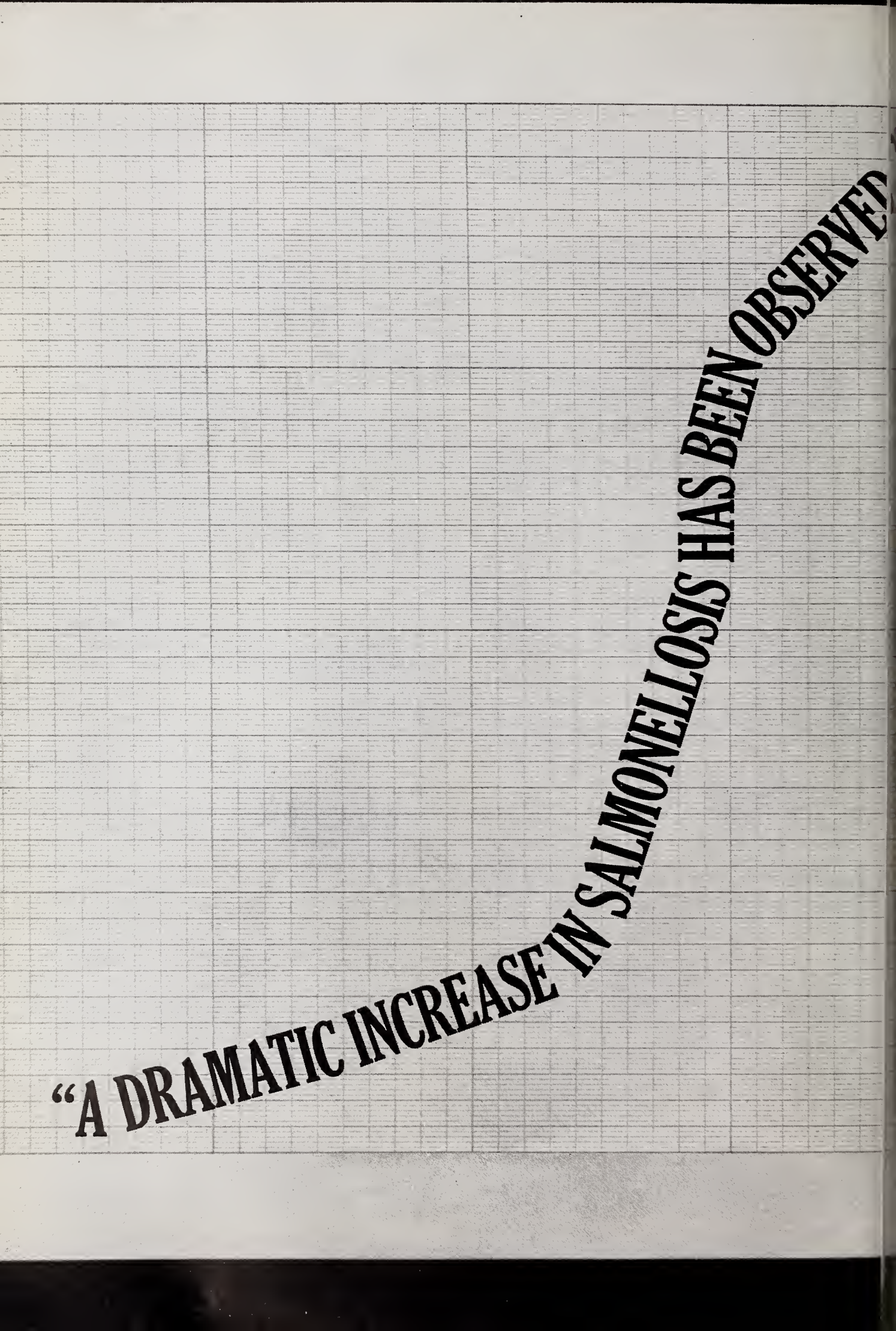
C. Joseph Stetler, President  
Pharmaceutical Manufacturers Association

• • • •

In 1965, about 1.9 million persons visited the Washington Monument. Had the 1935 death rate of TB, flu, pneumonia and syphilis continued to 1960, about 2 million persons—or more than the total who visited the

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<i>Salmonella choleraesuis</i>	<i>Salmonella derby</i>
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Proper antibacterial therapy for individual cases should help in reducing the total number of cases in an epidemic situation.

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*Do not give to infants under one month of age.*

**Composition:** Furoxone Liquid contains, per 15 cc. tablespoonful, furazolidone 50 mg., pectin 225 mg., and kaolin 3.0 Gm. Furoxone Tablets each contain 100 mg. of furazolidone.

**References:** 1. Editorial: J.A.M.A. 189:691 (Aug. 31) 1964. 2. Foertsch, J. H.: J. Oklahoma Med. Assn. 57:449 (Oct.) 1964. 3. Paul, H. E., and Paul, M. F.: The Nitrofurans—Chemotherapeutic Properties, in Schnitzer, R. J., and Hawking, F. (Eds.) Experimental Chemotherapy, Vol. 2, New York, Academic Press, 1964.

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## PULMONARY EMBOLUS

Joe M. Turner, M.D., *Tifton*

**P**ULMONARY EMBOLI are now recognized as a primary etiological factor in lung disease and a leading cause of death in hospitalized patients. They can be demonstrated on routine autopsy in 10% of general hospital patients, 25% of custodial-care patients, 50% of patients dying with heart disease, and when sought by special techniques, found in 64% of consecutive routine autopsies.

### High Risk Groups

High risk groups include patients with burns, congestive heart failure, obesity, malignancies, fractures, postpartum patients with previous history of phlebitis, and any person over 40 confined to bed rest three or more days. Pulmonary emboli originate in the leg veins in over 95% of cases. It is important to appreciate that 50% of these emboli result from phlebothrombosis where there is a total absence of physical signs.

### Preceded By Small Emboli

Large emboli resulting in death are usually preceded by multiple small emboli. The mortality lies somewhere between 20% and 38% with a recurrence rate of 44% in initial survivors. The commonest findings are a rise in pulse, respirations, and temperature. This triad constitutes an important clue since this may be the only manifestation of underlying embolization. More well-recognized signs and symptoms include cough, hemoptysis, pleuritic pain, friction rub, icterus, pleural effusion, and the cardiovascular manifestations of "acute cor pulmonale." Electrocardiogram and x-ray changes, pulmonary angiography, pulmonary scanning after injection of radioactive macroalbumin, radioactive clot detection techniques, and blood enzyme studies have made the laboratory a useful adjunct to diagnosis.

Therapy of pulmonary emboli consists of two parts, selected prophylactic treatment of patients

in high risk groups, and immediate treatment of overt pulmonary emboli. In prophylactic therapy, the success of anticoagulants in adequate doses has been repeatedly demonstrated. One such plan consists of 10,000 units of Heparin intravenously every six hours for six doses while simultaneous Coumadin type therapy is being instituted. Other prophylactic measures consist of leg elevation, instructions in "periodic foot wiggling," elimination of tightly tucked sheets, and avoidance of pressure points which obstruct venous return. The most notorious being the "broken bed," frequently used to prevent debilitated patients from sliding.

### Domain of Surgeon

The large embolus remains the domain of the surgeon with the Trendelenburg operation, or preferably, pulmonary embolectomy with a cardio-pulmonary bypass. Vena cava ligation is of proven value in patients with contraindications to anticoagulant therapy, or repeated emboli in spite of adequate anticoagulation. Immediate intravenous Heparin is still the treatment of choice for an acute pulmonary embolus and may be life saving. This should be continued until adequate oral anticoagulant therapy is established, and the latter continued for six to 12 months.

### Needless Cause

Pulmonary embolization usually constitutes a needless cause of death. The diagnosis and therapy is complex because of its multiple manifestations, which are a reflection of the physiologically related cardio-pulmonary systems. Constant awareness of its probability, and proper measures for its prevention are imperative for the better practice of medicine.

*101 East 12th St.*

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.





## THE BREAKDOWN IN MORALITY WHO IS RESPONSIBLE?

Harry R. Lipton, M.D., *Atlanta*

**T**HAT there has been a breakdown in morality no one can deny. The following is from the front page of this morning's *Atlanta Constitution*. Quote: "TEEN'S SEX CLUB BROKEN UP IN COBB, SAYS JUVENILE JUDGE."

About 20 or 25 young people were involved in the club. The girls ranged in age from 11 to 14 and the boys from 13 to 17.

### Living Up to Bad Name?

We do not publish the names of juvenile offenders; nevertheless, their misbehavior is continuously publicized in large type on the front page of newspapers. One may well wonder whether the youth of the nation today are living up to the bad name given them in the daily press.

Nationwide there is indifference to violence in everyday life, both at night and in broad daylight. Such violence is not confined to the subways of New York. Not long ago a woman was attacked during her lunch hour in the heart of downtown Atlanta. She screamed for help, yet no one came to her rescue. This happened even in Atlanta, which has the lowest crime rate for any city its size in the United States.

We are living in the age of the atom bomb, the drive-in theatre, and the oral contraceptive. The uncertainty of the times has a distinctly disturbing effect upon our youth; a good percentage of our youth expects to see atomic warfare during their lifetime.

### The Contraceptive

Our poorly lit and unpatrolled drive-in theatres are something we cannot be proud of. Not many of our teenagers go to these theatres to see the movie. Many of our teenage girls are either taking their mothers' oral contraceptives or buying their own. Until the ad-

vent of the oral contraceptive some mothers of teenage girls were having them fitted with diaphragms.

### Severe Breakdown

There has been a definite and severe breakdown in our American family life. A large percentage of American mothers work. Many of the others are involved in community work, club activities, and not too many are deeply involved in what their teenage children are doing. The fathers are preoccupied with their work and activities, and no longer serve as heads of their households.

Cheating under the honor system has not been confined to the Air Force Academy or any other school system.

Our radio and television programs are not particularly healthy for adults, let alone our youth. Sex, promiscuity, drinking, cheating, murder and mayhem are dramatized. Many of our popular movies are centered about the bedroom.

During the past two generations we have evolved from a patriarchal to a matriarchal society. The average boy from a stable home between 11 and 18 is emotionally identified with and closer to his mother. Many such boys will reveal that "Father is reliable, but Mother is understanding." What the boy cannot get from father, he gets from mother; the authority of the father is gone.

We spend billions to beat the Russians to the moon, but very little to eradicate the social ills: poverty, illiteracy, delinquency, and mental illness. It will be up to the older generation to set a better example in morality for their children and for government agencies on all levels to cope realistically with our social problems.

*490 Peachtree Street, N.E.*

*Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.*

## "CIRCUIT COURSE" POSTGRADUATE EDUCATION CONTINUES THROUGH MAY

The 1965-1966 Georgia "Circuit Courses," sponsored by the Medical Education Board of the Medical Association of Georgia, and the Medical College of Georgia, Augusta, will continue through May as follows:

Waycross/Memorial Hospital

March 29—Cardiovascular Disease

April 26—Renal and Urinary Tract Diseases

Moultrie/Colquitt Hotel

March 30—Cardiovascular Disease

April 27—Renal and Urinary Tract Diseases

Dublin/VA Center Hospital

March 31—Cardiovascular Disease

April 28—Renal and Urinary Tract Diseases

Toccoa/Georgia Baptist Assembly Grounds

April 12—Optic, Neurological and Medical Disorders

May 10—Arthritis

Dalton/Hamilton Memorial Hospital

April 13—Optic, Neurological and Medical Disorders

May 11—Arthritis

Thomaston/Upson County Health Building

April 14—Optic, Neurological and Medical Disorders

May 12—Arthritis





## DEATHS

**Jesse Hardman York** of Atlanta died December 23, 1965. Dr. York was a graduate of Mercer University and the Emory University School of Medicine. He served his internship at Grady Memorial Hospital, Atlanta, and did postgraduate work at Boston; New York; Philadelphia; New Haven; Cleveland; Madison, Wisconsin; San Francisco and Cincinnati. He had practiced medicine in Atlanta since 1930. He was a Fellow of the American College of Surgeons, and a member of the Southeastern Surgical Congress. Surviving are his sisters, Mrs. Shelley C. Davis, Mrs. R. M. Mitchell, Jr., Mrs. Edward F. Grady, Miami; brother, Mr. John L. York, Washington, D.C.; nieces, Mrs. William G. Sewell, Mrs. Jack Caldwell; and nephew, Dr. S. Carter Davis, Jr.

**J. H. Hodges, Sr.**, Hapeville, died January 31, 1966. Dr. Hodges graduated from the Emory University School of Medicine and did postgraduate work at Cook County Hospital, Chicago, and the Medical College of Georgia, Augusta. He was a member of Fulton County Medical Society, Southern Medical Association, the Railway Surgeons Association, and the Industrial Surgeons of America. He is survived by his son, Mr. James H. Hodges, Jr., Hapeville; daughters, Mrs. D. W. O'Quinn, Miami, Florida; Mrs. J. H. Summerour, Winder; Mrs. C. G. Burt, Atlanta; and his sister, Miss Susie Mae Hodges, Sandersville.

**J. Elliott Scarborough, Jr.**, 59, of Atlanta, one of the nation's outstanding cancer specialists, died January 31, 1966, in Emory University Hospital. He succumbed to the disease he spent a medical lifetime fighting.

Since coming to Atlanta in 1937 to direct the Robert Winship Memorial Clinic, Dr. Scarborough had been a leader in developing Emory's Medical Center and in expanding Emory University Clinic, of which he became director in 1957.

He held a Rockefeller Clinic Fellowship at Memorial Hospital in New York when he was invited here to head up the tumor clinic being established in the Robert Winship Memorial Clinic, one of the first for diagnosis and treatment of cancer in this area. Under Dr. Scarborough's guidance it became nationally known.

In addition to his original assignment as director of the Robert Winship Clinic, Dr. Scarborough held teaching positions in the Emory Medical School, beginning as instructor in surgery in 1937 and rising to professor of surgery in 1957. In the same year he became director of Emory University Clinic and director of professional services in Emory University Hospital.

In 1949 he was appointed to the National Advisory Cancer Council, the government's top policy-making scientific group in cancer research. In 1955 he was named to the national board of directors of the American Cancer Society and reelected in 1959. He also

served as a member of the cancer committee of the American College of Surgeons.

In 1956 Dr. Scarborough was chosen president of the James Ewing Society, composed of doctors prominent in treatment and research of cancer and other neoplastic diseases. In the same year he received the American Cancer Society's award for distinguished service in cancer control. He had served as chairman of the executive committee of the Georgia Division since 1952.

In 1960 he was appointed a member of the Cancer Research Training Committee of the National Cancer Institute and served until 1964.

Dr. Scarborough was a Diplomate of the American College of Surgeons, and the American Board of Surgery. In addition he was a member of the American Medical Association, the Medical Association of Georgia and the Fulton County Medical Society.

Born July 26, 1906, in Mt. Willing, Alabama, he received his A.B. degree at the University of Alabama in 1926 and his M.D. degree at Harvard Medical School in 1932. He served a surgical internship at Roosevelt Hospital in New York, then continued his training at Memorial Hospital before coming to Atlanta.

He was an elder in the First Presbyterian Church. He served as a director of the Great Southern Real Estate Trust.

He was a member of the Piedmont Driving Club, Capital City Club and Kappa Alpha fraternity. Emory students recently chose him as an honorary member of ODK leadership fraternity.

Dr. Scarborough is survived by Mrs. Scarborough, the former Isabelle Wisell of Middlebury, Vermont, their two daughters, Mrs. Nancy Cottraux of Atlanta and Mrs. Joseph H. Long of Dallas, Texas. Their son, Elliott III, is a college student and another son, Evans H. attends Darlington in Rome. He is also survived by his mother, Mrs. Mattie Hinson Scarborough, and six grandchildren.

**Gabe W. Willis**, Ocilla physician, died January 10, 1966. Dr. Willis received his medical degree from the University of Chattanooga and did postgraduate work in surgery at the Mayo Clinic, Rochester, Minnesota.

He practiced medicine in Insley, Alabama, until 1911 when he moved to Irwin County to become an associate with his brother-in-law, Dr. W. J. Dismuke.

In 1914 Dr. Willis and Dr. Dismuke founded the first hospital in Irwin County in the Western Height section of Ocilla.

After Dr. Dismuke's death in 1920, Dr. Willis became owner and chief surgeon of the hospital.

In 1934, Dr. H. L. Dismuke, son of the late Dr. W. J. Dismuke, became associated with Dr. Willis.

They continued this operation until 1953 when the present Irwin County Hospital was opened.

Following the opening of the hospital Dr. Willis became a member of the medical staff. He was also a member of Phi Chi Medical Fraternity, the Ben Hill-



Irwin Medical Society, Medical Association of Georgia, American Medical Association, Southern Medical Association. A member of the Ocilla Methodist Church, Dr. Willis was a Mason, Knight Templar, Shriner and a member of the Board of Stewards of the Ocilla Methodist Church.

Survivors include: The widow, Mrs. Louise H. Willis, Ocilla; one daughter, Mrs. Harriet W. Waddill, Ocilla; one grandson, John M. Waddill, Jr., Gainesville; one granddaughter, Mrs. Kay W. Justice, Fitzgerald; two brothers, O. A. Willis, Cottonton, Alabama, and F. M. Willis, Bremerton, Washington; three sisters, Mrs. Mamie Willis, Mrs. Agnes Monk, both of Columbus, and Mrs. J. A. Avery, Greensboro, North Carolina, and six great grandchildren.

## COUNTY MEDICAL SOCIETIES

Charles S. Jones, M.D., Atlanta surgeon, has been appointed Chairman of a study committee on the new Medicare law by John T. Godwin, M.D., Atlanta, President of the **Fulton County Medical Society**. Other members of the committee are: Drs. Edward C. Evans, Edward C. Loughlin, R. J. Van de Wetering, Edgar D. Grady, Robert E. Wells, Frank L. Wilson, Haywood N. Hill, Mark P. Pentecost, Jr., Thomas J. Anderson, Jr., M. Bedford Davis, S. P. Weinberg, J. Lamar Mays, C. R. Moorhead, Robert F. Finegan, Albert A. Rayle, Jr., H. Vince Bell and Robert B. Hornberger.

**Gordon County Medical Society** has elected the following officers for 1966: President, W. D. Hall, M.D.; Vice President, Lewis R. Lang, M.D.; and Secretary, Jack Gent, M.D. Delegate to Medical Association of Georgia is J. L. Rabb, M.D., and Alternate Delegate is Dr. Lang. All are from Calhoun.

## PERSONALS

### First District

The medical staff of Warren A. Candler Hospital, Savannah, was installed January 19, 1966, and are as follows: New Chief of Staff, **Dr. Harry E. Rollings**, who succeeds **Dr. J. Kirk Train**. Other incoming officers are **Dr. Jeff J. Holloman**, Treasurer, and **Dr. Harvey V. Morgan**, Secretary.

Chiefs of clinical departments at Candler for 1966 are **Dr. Julian K. Quattlebaum, Jr.**, Department of Surgery; **Dr. Benjamin L. Pike**, Department of Medicine; **Dr. W. W. Osborne**, Obstetrics and Gynecology Department; **Dr. Harold W. Smith**, Department of General Practice; **Dr. Franklyn P. Bousquet, Jr.**, Department of Ophthalmology and Otorhinolaryngology; **Dr. Harry Portman**, Department of Pediatrics; **Dr. Joseph McCormick**, Department of Pathology, and **Dr. David Robinson**, Department of Radiology.

Judge B. B. Heery, president of the board of trustees, presented a silver bowl to Dr. J. Kirk Train for his leadership and service as chief of the medical and dental staff for 1965.

**Peter L. Scardino**, Savannah, has been appointed to a three-year term on the Residency Review Committee on Urology. He will be the representative of the American Medical Association Council of Education.

The six-member board reviews residency programs in urology at hospitals and medical schools throughout the country.

Dr. Scardino is President-Elect of the Georgia Medical Society and President of the Memorial Hospital medical staff.

**Thomas A. McGoldrick, Jr.**, Savannah, moderated a panel discussion on "You and Your Heart," January 10, 1966, at the Jewish Educational Alliance.

The panel discussion followed a talk by **Dr. Joseph Pacifici** on "After the Stroke What?"

Others on the panel included **Dr. J. Reid Broderick**, **Dr. Murray C. Arkin** and **Dr. W. G. Williams**. They discussed stroke rehabilitation.

This was the third in a series of public forums sponsored by the First District Chapter of the Georgia Heart Association, the Georgia Medical Society and the Chatham County Health Department.

**Dr. Michael H. Whittle** of Lyons has been named Chief of Staff at Meadows Memorial Hospital for 1966, succeeding **Dr. Henry de Jarnette** of Vidalia.

**Dr. J. Everette Barfield** of Vidalia was named Secretary-Treasurer, succeeding **Dr. Travis Nobels** of Lyons.

### Third District

**J. C. Serrato, M.D.**, Columbus, recently attended a meeting in Washington, D.C., for the U.S. State Department's Agency for International Development (AID).

The meeting drew together representatives of more than 20 voluntary U.S. agencies working for refugees in cooperation with Project Viet Nam, which recruits medical personnel for the Southeast Asian country.

Dr. Serrato is Director of the Inter-American Council for Medical Assistance, Education and Research in Columbus, which recruits personnel from this area and Latin America.

### Fourth District

At a recent meeting of the medical staff of Sylvan Grove Hospital, **Dr. Jack Newman** was named Chief of Staff for 1966 with other officers as follows: **Dr. W. G. Hicks**, Vice-Chief of Staff; **Dr. J. C. Howell**, Secretary-Treasurer.

Other staff members include **Dr. F. M. Holston** and **Dr. Bailey Crockarell**.

### Fifth District

**Olin S. Cofer, M.D.**, Atlanta physician and surgeon, has been elected to serve as Chairman of the Board of Trustees of Truett-McConnell College, Cleveland, Georgia.

Guest speaker at the Covington Kiwanis Club luncheon meeting January 20, 1966, was **Charles R. Hatcher, Jr.**, M.D. of Atlanta. Dr. Hatcher is a thoracic and cardiovascular surgeon.

**Sydney Olansky, M.D.**, Atlanta, was recently a guest lecturer, January 12-15, 1966, at Stanford University School of Medicine, Palo Alto, California, and the University of California, San Francisco. He was also a guest at the Meeting of the Dermatology Society of San Francisco at Letterman Army Hospital.



## THE ASSOCIATION / Continued

**Bruce Logue, M.D.**, Atlanta, recently addressed the Tenth District Medical Society in Washington, Georgia. The title of his talk was "Re-evaluation of the Current Therapy of Myocardial Infarction." The second talk was given under the auspices of the Washington-Wilkes County Heart Council in a public forum at Washington High School. The title of the talk was "Who Is Susceptible to a Heart Attack."

Atlanta physician, **Maxwell Berry**, was installed as President of the American College of Gastroenterology at the group's meeting in Bal Harbour, Florida.

**Drs. John E. Skandalakis, Stephen W. Gray and Duncan Shepard**, Atlanta, were awarded third prize in the 1965 Rorer Award Contest by the American College of Gastroenterology for their paper "Smooth Muscle Tumors of the Small Intestine," which appeared in the August, 1964 issue of *The American Journal of Gastroenterology*.

**Drs. Dale Cooper, Joseph L. Izenstark and H. S. Weens**, in conjunction with the Department of Ob-Gyn, Emory University School of Medicine, Atlanta presented a paper on "Placental Scanning" at the recent Radiological Society of North America meeting in Chicago. Dr. Izenstark gave a refresher course on "The Use of Isotopes in Abdominal Conditions." **Dr. Ralph Hines** was on a panel discussing "Cerebral Angiography." **Drs. Robert G. Sybers, Wade H. Shuford** and **Weens** presented a paper and exhibit on "The Diagnosis of Pericardial Effusion with Contributing Agents." Dr. Weens and **William Miller** and **Perry Sprawls** presented a paper on "Fluoroscopic X-Ray Exposure Doses."

**A. H. Letton, M.D.**, Atlanta surgeon and member of the Georgia Division, American Cancer Society Board of Directors, has been named to head the Society's National Public Education Committee.

Dr. Letton has been a member of the Georgia and National ACS Boards for over ten years. He is currently Chairman of the Georgia Professional Education Committee.

### Sixth District

**Thomas L. Ross, Jr.**, Macon cardiologist and one of the founders of the Georgia Heart Association, will serve as chairman of the special gifts division of the 1966 Heart Fund campaign in Bibb County.

Dr. Ross is a director of the American Heart Association as well as of the Georgia Heart Association. He was elected vice president of the Georgia association in 1948 and served as its president in 1952. He also founded the Macon Heart Clinic which is staffed by a number of volunteer physicians each week at Macon Hospital.

**J. T. Hogan, Jr., M.D.**, has been elected President of the medical staff of Middle Georgia Hospital, Macon, succeeding **John O'Shaughnessey, M.D.** Also elected were **Dr. Ralph Newton, Jr.**, Vice President; **Dr. H. M. Olnick**, Secretary; **Dr. Ben Bashinski**, Chief of Surgery; **Dr. H. K. Sealy**, Chief of Medicine; and **Dr. C. R. Ireland**, Chairman of the Credentials Committee.

Thirty-six physicians are included on the Macon Hospital's honorary and consultant medical staffs for 1966.

On the Honorary Staff are **Dr. Wallace L. Bazemore**, **Dr. W. E. Mobley** and **Dr. Charles L. Ridley, Sr.**

The consultant staff is as follows:

Surgery—**Drs. Thomas Harrold, O. F. Keen, C. H. Richardson, Sr.**, and **H. G. Weaver**.

Medicine—**Drs. J. D. Applewhite, H. C. Atkinson, W. W. Chrisman, J. F. Hanson** and **W. W. Merriwether**.

Obstetrics—**Drs. Leon J. Goodman, J. L. King, Sr.**, **Evelyn Swilling** and **O. R. Thompson**.

Gynecology—**Drs. J. C. Anderson, R. W. Edenfield** and **Raymond Suarez**.

Genitourinary—**Drs. Ernest Corn** and **Willard R. Golsan**.

Orthopedics—**Drs. J. I. Hall** and **W. A. Newman**.

Pediatrics—**Dr. R. C. Goolsby**.

Ear, Nose and Throat—**Dr. W. H. Holden**.

Dental—**Drs. W. B. Childs, Frampton Farmer** and **C. A. Yarborough**.

Public Health—**Dr. R. J. Walker, Jr.**

Ophthalmology—**Dr. C. K. McLaughlin**.

Proctology—**Dr. A. M. Phillips, Sr.**

Teaching Consultant Staff, Obstetrics and Gynecology—**Drs. Charles I. Bryans, Jr., Preston L. Wilds** and **Frederick Zupan**.

Surgery—**Dr. William Moretz**.

**Dr. Thomas H. Williams** has been elected chief of the medical staff of Macon Hospital for 1966.

Other officers elected included **Dr. Oscar S. Spivey**, Chief of Staff-elect; **Dr. John I. Hall**, President of Staff; **Dr. E. C. McMillan**, Vice President; **Dr. E. H. Stanley**, Secretary-Treasurer; and **Dr. David S. Mann**, Parliamentarian.

### Seventh District

**James H. Smith, M.D.**, Rome, was the guest speaker at the Calhoun Optimist Club January 13, 1966. A film, "Coronary Heart Disease," was shown during the program.

**Charles W. Smith, M.D.**; **R. Mitchell, M.D.**; and **James L. Cross, M.D.**, have opened offices in the Austell Hospital Building for the practice of obstetrics. All three doctors are Diplomates of the American Board of Obstetrics and Gynecology and the American College of Obstetrics and Gynecology. They also have offices in Atlanta where they have been in practice for several years.

### Eighth District

**Y. Franklin Carter, M.D.** of Nashville has received a Presidential appointment to serve as Medical Advisor to Selective Service Local Board Number Ten.

Dr. Carter has previously received a similar confirmation of his competence through appointment to the Georgia State Board of Medical Examiners. He served as President of this body for the recently concluded year. It is the task of the Board of Medical Examiners to pass upon the readiness and adequacy of preparation of aspiring young physicians to practice their profession.

The State Board of Health recently welcomed a new member, **William A. Dickson, M.D.**, of Nashville. He replaced **Dr. Duncan B. McRae**, who resigned his appointment. The Board unanimously adopted a formal resolution thanking Dr. McRae for his services to the Board.



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**Cover**

The subject of the April cover is the gold meritorious service medallion of the Georgia Heart Association.





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possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

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rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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# PLACENTOGRAPHY: A COMPARISON BETWEEN X-RAY AMNIOGRAPHY AND SAC DISTENTION METHODS

Eduardo Talledo, M.D.; W. F. Carter, M.D.,  
and F. P. Zuspan, M.D., *Augusta*

- The observations made in this study are based on a method described by Torpin in 1938.

SINCE MENEES ET AL<sup>7</sup> introduced amniography in 1930, there have been spurts of interest for the method in this country<sup>2, 6, 10</sup> and abroad.<sup>1, 4, 5, 9</sup>

One of the drawbacks may have been the lack of familiarization with the technique for amniocentesis. Cornell and Case<sup>2</sup> found it too risky; their major objection being a laceration of a fetal vessel. In each of the six cases they studied the placenta was punctured. They discontinued the use of amniography. Kerr and MacKay<sup>4</sup> used it in ten cases. Fetal death occurred in three cases of severe bleeding. They thought amniography was of limited value.

## A Negative Factor

The contrast media used in earlier studies may have added a negative factor, for Burke<sup>1</sup> used amniography for induction of labor with high success. He was able to induce labor in 26 out of 27 patients, including abortions. The average latent period at term was 23 hours, 35 minutes. Between the 18th and 28th week it was four to five days. Menees et al<sup>7</sup> using strontium iodide encountered labor only once in 25 cases. McLain<sup>6</sup> found no cases of premature labor attributable to the procedure in 75 patients using hypaque 75%. Since there is a modern trend to avoid radiation on the pregnant woman, whenever localization of the placenta becomes necessary, amniography offers the advantage of producing more reliable results than more conventional roentgenological studies.

Localization of the placenta by radioisotope techniques is not practical, as it requires special equipment and trained personnel in the handling of the

radioactive material. Contrarily, every obstetrician is potentially capable of performing amniocentesis, and consequently, amniography. Furthermore, by keeping in mind certain radiological principles, he will be able to interpret the films accurately.

Torpin<sup>12</sup> in 1938 described a method of studying placenta by distention of amniotic sac. It is based on this method that the present observations have been made.

## Methodology

Whenever possible, the placentas from patients in whom amniography was performed were studied by Torpin's method. The membranes must be intact except for the area around the cervix where the fetus comes through during delivery. Care was taken to indicate at the time of delivery whether the placenta was attached to the uterus anteriorly or posteriorly. Photographs were taken of the placenta whose amniotic sac was distended in AP and lateral positions—roughly, the same projections in which the x-rays were taken. After observations were made, it was obvious that a perfect match was not possible and this was expected. The sac distention method, however, could corroborate whether or not the defect seen on the x-ray was due to the placenta. By retrospective study of the x-rays and the photographs of the placentas, it is possible to become familiar with the various radiological features that the amniogram may present.

The second part of the study, the distention of the amniotic sac, was done with barium. X-rays and photographs of the placenta in several incidences were taken and matched.

Aided in part by Grant No. HE-09289-02 from the National Heart Institute.



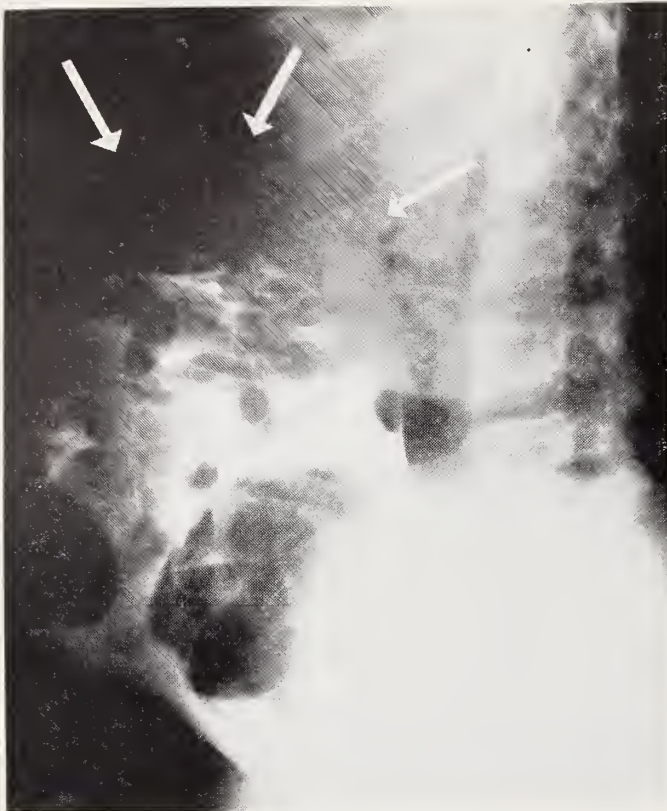


FIGURE 1 (a)

Shows a lateral projection of the x-ray (amniogram). The placenta is high on the posterior wall.



FIGURE 1 (b)

The photograph after the amniotic sac has been distended with saline.

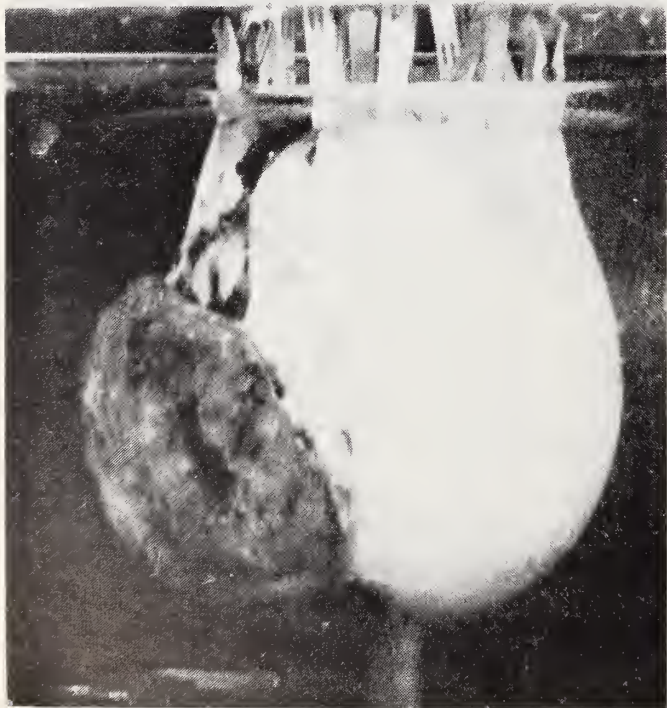


FIGURE 2 (a)

Amniotic sac distention has been done with barium. Photographs and x-rays were taken sequentially. The effects of the positional changes of the placenta on the x-rays are apparent. Notice that when the placenta is located entirely on the posterior wall, no defect is seen on the x-ray.

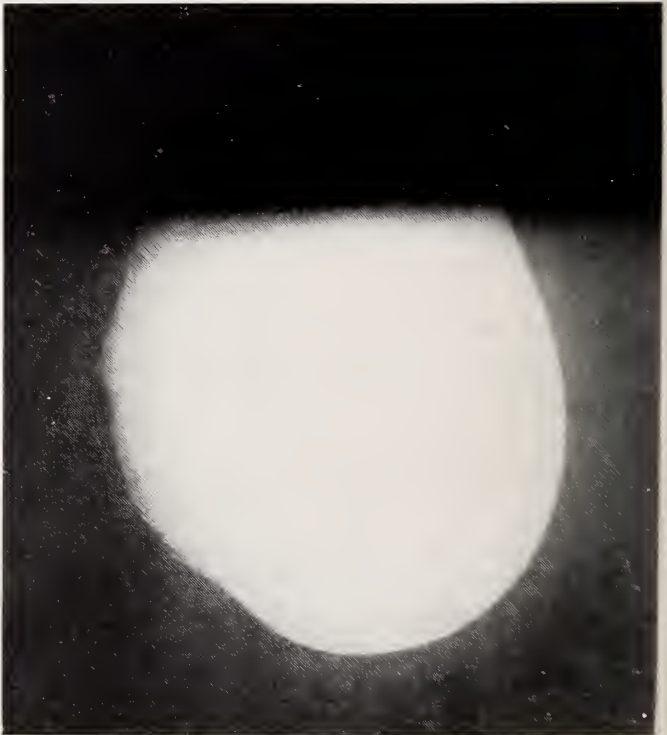


FIGURE 2 (a)





FIGURE 2 (b)



FIGURE 2 (b)



FIGURE 2 (c)

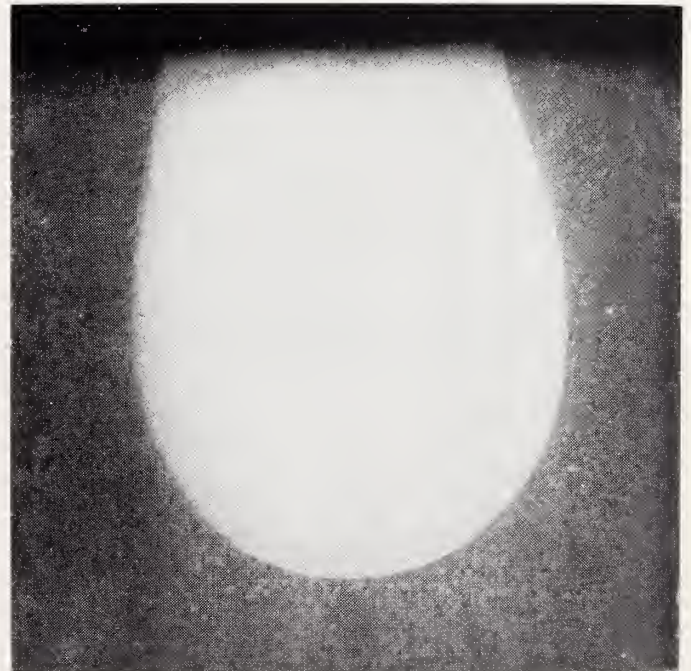


FIGURE 2 (c)

Throughout the literature<sup>3, 8, 13</sup> placentography, by soft tissue technique studies, rates as 90% or better in accuracy. When one considers that the placenta can be localized directly only when it is located high in the body of the uterus, it is remarkable the results that are achieved. Most writers agree that conditions such as obesity, multiple pregnancy, low implantations, fecal material in the colon, excessive intestinal gas, and transverse and breech presentations make interpretation by this technique haz-

ardous. Additional films are often required using injection of dye or air into the bladder and occasionally into the rectum<sup>8</sup> to aid in placental localization, complicating the simplicity of the procedure and increasing the radiation to the fetus and maternal gonads. Moreover, in the event that the placenta is localized in low position, the variety of previa cannot be ascertained from the films, making examination under double set-up often necessary.

With the popularization of amniocentesis in recent years for diagnostic, research and therapeutic purposes,<sup>11</sup> the technique of amniocentesis seems to be no longer a major obstacle for amniography.



The opacification of the amniotic fluid makes localization of the placenta relatively easy, even for the unexperienced eye. One film in lateral position is usually all that is required. The placenta is viewed as a "filling defect." We can see that when the placenta is located entirely over the posterior or anterior walls, it will not be seen on the PA film. When the edge of the placenta turns over the opposite wall, the defect is small and may simulate small defects as seen in pregnancies associated with uterine fibroids. The bulk of the placenta is best seen on the lateral projection. The opaque medium unable to pool behind the placenta may decrease the "filling defect" in the outline of the amniotic contour, but will not render it invisible. According to available reports, amniography is more accurate than the most commonly employed placentogram. A definite advantage is that the placenta is localized directly, whatever its position may be.

Our purpose is not to discredit the placentogram by soft tissue technique studies, but rather to stimulate further trials with amniography.

### Summary

Correlative studies for placental localization between the x-rays from amniograms and photographs taken from placentas after distention of the amniotic sac are presented.

Radiological and photographic views of a placenta whose amniotic sac was distended with barium are also shown.

Brief comments are offered of the advantages of

amniography in localization of the placenta when compared to more conventional radiologic techniques.

### Acknowledgment

We are deeply grateful to the department of Radiology for the help they have given us with the technical aspects of this study.

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Department of OB-GYN  
Medical College of Georgia

## "GEORGIA HEART HOUR"

### PRESENTED EACH MONTH ON TV

The eighth in the current series of television programs presented by the Georgia Heart Association for physicians will be seen May 2-3 on the Georgia Educational Television Network. It is entitled "Recognition and Treatment of the Commoner Forms of Congenital Heart Defects."

Guest faculty is Mary Allen Engle, M.D., Associate Professor of Pediatrics, Cornell University Medical College and S. Frank Redo, M.D., Clinical Associate Professor of Surgery, Cornell University Medical School, New York.

A part of the "Georgia Heart Hour" series, this program will be telecast from 10:30-11:30 p.m. Monday, May 2, and repeated at the same time on Tuesday, May 3.

## TOUR OF AMA HEADQUARTERS A CONVENTION HIGHLIGHT

A special feature of the American Medical Association's 115th Annual Convention will be a guided tour of AMA headquarters and the new Institute for Biomedical Research.

All physicians, their wives and other convention guests are invited to tour the building. Tours will be conducted every hour from 9 a.m. to 4 p.m., Monday, June 27 through Friday, July 1.

A special corps of guides will escort the visitors and answer any questions regarding AMA publications, services and activities.



# THE PRINCE AND PROPHET

Herbert S. Alden, M.D., *Atlanta*

**M**AN HAS BEEN victim of psoriasis even before Job scratched himself with a potsherd.

The striking symptom of psoriasis—occurring almost wholly as an eruption of the skin, readily visible and palpable, associated with little or no symptoms of physical disease—fascinated and puzzled the ancients even as it does modern people. And so it is not surprising that the Greek and Roman physicians such as Hippocrates and Celsus observed and described this disease.

The words *psora* and *lepra* are examples of the Greek terminology meaning “any skin disease” or, as a young Greek physician recently told me when I asked the meaning of these two words in ancient and modern Greek, “*Psora* means a ‘bad skin disease’ but *lepra* means a ‘worse bad skin disease.’”

## Term Was Born

And so the term *psora* and its suffix *iasis* meaning “like psora” was born and the word *psoriasis* has grown in common usage as the only term for this skin eruption. But 150 years ago this disease was first described in English text as “*lepra vulgaris*” and even in this century has been known as “the white leprosy.” But the association with the word leprosy was too repugnant to the common man for such a term to be continued. So today after many generations of observation I think we are safe in assuming that we are dealing with a hereditary condition rather than a disease, and a hereditary condition frequently with racial overtones (rare or non-existent in the Negroid race and much more frequent in the semitic peoples).

While the distribution of the eruption of psoriasis on the skin of the body varies widely, its particular clinical appearance does not i.e., circumscribed plaques covered with white scales. The eruption of psoriasis lacks certain characteristics of the usual dermatoses. This absence is a great aid in the diagnosis. For instance, it rarely produces symptoms,

## ■ A case report of psoriasis

that is, itching; it is not vesicular; and it does not produce scarring even in the most severe eruptions. Since the eruption occurs predominantly on areas of rubbing or injury, that is, the scalp, elbows, knees, and saddle of the trunk; and since it is by observation in history hereditary; and since it is histologically confined to the upper layers of the skin, and can be reproduced in susceptible individuals; and since there is often spontaneous regression and resurgence, I prefer to look upon psoriasis as a hereditary condition produced by many sorts of injuries in a susceptible individual, wholly cutaneous in nature and in appearance. The fascinating appearance of a wall-paper-design-like eruption is well enough known, but the mechanism of the production of these eruptions is not often appreciated.

## The Psoriatic Skin

One of the most adequate and characteristic methods that the hide has for protection lies in the rapid over-growth of the upper layers, producing thickening and callousing as a barrier to the further invasion of the dermis. This is an orderly increase in the keratin layers. In the psoriatic skin this takes place also, but in a more disorderly fashion, resulting in a rapid growth of the basal cells which push their dying brothers outward so fast that the cell has little time to lose its nucleus, and thus adhere one to another in the keratin layer. This results in the rapid over-growth of silvery scales and also in pressure of cells downward into the dermis, increasing the length and depth of the basal layer, causing exaggerated papillae. Because of this, it is quite simple to scratch the silvery crust, and by causing very little pain produce a bleeding point.

This orderly growth of cells from the base to the top ordinarily takes three to four weeks, but in the psoriatic it is much more rapid. This often accounts for the dramatic clearing of the eruption, and is

Read at the One Day Postgraduate Program of the Department of Medicine, Emory University School of Medicine, Saturday, December 18, 1965.



occasionally a cause of much surprise to both the patient and the doctor.

If then one could find methods that would defeat, reduce, or kill this excess epithelial growth and not interfere with the protective mechanisms of the skin, then such therapy would be expected to be effective. Such is actually the case. Any mild oxidizing agents, short of injury, have for many years been known to be helpful, such as, sunlight or ultra violet radiation. The use of Grenz ray and the x-ray is efficacious, since it produces death of the rapidly growing epithelial cells. Both are helpful, but the margin of safety is strongly in favor of the Grenz ray. The use of oils, oil emulsion baths with soap, followed by chemical oxidizing agents in ointments or salves, such as, ammoniated mercury, salicylic acid, tar distillates, resorcinol, chrysarobin, etc., all have for many years been found to be helpful. This statement even extends to the well advertised "Tegran" which is allantoin and tar distillates in a water miscible base. But note that it is advertised more extensively in the spring and early summer when the sunlight normally effects relief in the psoriatic.

Dramatic Improvement

All of these methods have been well employed by the dermatologist, but in recent years there has been dramatic improvement in the care of the psoriatic with the use of the newly discovered carcinogenic chemicals, especially the folic acid antagonists. I refer to the drugs Aminopterin, Methotrexate, and Thioguanine, all of which are now referred to as "the newer antipsoriatic therapeutic agents." These agents even in very small concentration produce the death of epithelial cells—the epithelial cells of the skin as well as the blood forming organs—probably by interfering with the transference of the DNA and the RNA synthesis in the cell itself. So in certain extensive forms of psoriasis, these drugs have been found ideal if used with judgment and caution, and curiously enough, have been found effective in ridiculously small doses, as low as 2½ to 5 mgs. given once weekly. These drugs can be given in large single doses once a week, either by vein or by mouth.

But psoriasis is a condition that is as changeable as the patient's emotions, and is as involved as are his family and marital problems. In order to illustrate the many facets of its care and treatment, a case report might be helpful and interesting.

This patient lived sometime in the mid-portion of the Eighth Century B.C. in the city of Damascus in the country of Syria, about 150 miles north of the

Sea of Galilee and about 150 miles, as the crow flies, from the city of Tel-Aviv, Israel. It was a time much like ours. A people having begun as nomads had passed through an agrarian revolution and had now become a commercial community in cities. These people were rich and prosperous and given to characteristic tempers and moods of city life, such as, fractiousness, irritability, and panic in crowds. They were fat on luxury and given to false notions in art and artificial conditions of life. As now, they had physicians—good, bad, crafty, and keen, and they had specialists called, "prophets" which no doubt were of the same nature.

The following account of the meeting between the Prince of Syria (with psoriasis) and the Prophet of Israel (with a cure) is told in the fifth chapter of Second Kings in the Holy Bible. It is full of frankness, suspicions, guile, politics, and money, as are most of the stories in the Old Testament. (I have been called to account in the past by some ministers and preachers for using the word *psoriasis* here, instead of *leprosy*, but I have good authority for this assumption in the recent translation of the Torah. This Hebrew Torah was translated by Jewish scholars in Alexandria into Greek from which the Latin scholars derived the King James version of the Holy Bible. The Greeks, as I have mentioned above, use the words *psora* and *lepra* interchangeably.) I think it is reasonable to assume that *lepra* and *psora* are the same Biblical disease.

Naaman Cured of His Leprosy (Psoriasis)

"Now Naaman, the commander of the army of the king of Syria, was a great man with his master and highly esteemed, because through him the Lord had given victory to Syria. But although a valiant man, he was a leper. The Syrians had gone out as marauding bands and had carried off a little girl from the land of Israel, and she waited on Naaman's wife.

"Would that my master were with the prophet who is in Samaria!" she said to her mistress. "Then he would cure him of his leprosy."

So he went and told his lord, saying,

"Thus and so spoke the maiden who is from the land of Israel."

Then the king of Syria said,

"Go now, and I will send along a letter to the king of Israel."

So he set out, taking with him ten talents of silver and 6,000 shekels of gold and ten festal garments:\*

\* Estimate in 1934 of the fee brought to "Doctor" Elisha by Prince Naaman (a psoriatic) of Syria, about 750 B.C.  
6,000 Gold Shekels @ \$10.88 ..... \$65,280.00  
10 Silver Talents @ \$2,176.00 ..... \$21,760.00  
10 "Prayer Robes" @ \$100.00 (?) ..... \$ 1,000.00  
Total ..... \$88,040.00



and he brought to the king of Israel the letter which read,

"Now when this letter reaches you, be informed that I have sent to you my servant Naaman, that you may cure him of his leprosy."

When, however, the king of Israel read the letter he tore his garments, and said,

"Am I a god to kill and make alive, that this man is sending to me to cure a man of his leprosy? Take note and observe how he is seeking occasion against me."

But as soon as Elisha the man of God heard that the king of Israel had torn his garments, he sent to the king saying,

"Why have you torn your garments? I pray you let him come to me, that he may know that there is a prophet in Israel."

So Naaman came with his horses and with his chariots and halted at the door of Elisha's house. Whereupon Elisha sent a messenger to him, saying,

"Go wash in the Jordan seven times, and your flesh shall be restored and you shall be clean."

But Naaman was enraged and left, and he said,

"Here I have been saying to myself, 'He will surely come out and stand and call on the name of the Lord, his God, and wave his hand toward the place and cure the leper.' Are not Amana and Pharpar, the rivers of Damascus, better than all the waters of Israel? Could I not wash in them and be clean?"

So he turned and went away in a rage. Then his servants came near and spoke to him, saying,

"My father, if the prophet had demanded of you some great thing, would you not have done it? How much rather then, when he said to you, 'Wash and be clean?' "

So finally he went down and dipped himself seven times in the Jordan, according to the word of the man of God, and his flesh was restored like the flesh of a little child, and he was clean.

Then he returned to the man of God, with all of his retinue, and came and stood before him and said,

"Verily, now I know that there is no God in all the earth, but in Israel; now therefore, I pray you, accept a present from your servant."

"As the Lord lives whom I serve, I will take nothing," he said.

And although he pressed him to take it, he refused.

"Go in peace," he said to him.

But when he had gone from him a short distance, Gehazi, the servant of Elisha the man of God, said,

"See, my master has spared this Syrian, Naaman, without accepting from his hand what he brought! As the Lord lives, I will certainly run after him and get something from him."

So Gehazi ran after Naaman, and when Naaman

saw someone running after him, he alighted from his chariot to meet him, and said,

"Is it well?"

"All is well," he said. "My master sent me, saying, 'There have just now come to me two young men of the prophetic order from the highlands of Ephraim. I pray you, give them a talent of silver and two festal garments.' "

"Consent to accept two talents," said Naaman.

So he urged him, and tied up two talents of silver in two bags, with two festal garments, and he gave them to two of his servants, and they carried them before him. But when he came to the hill, he took them from their hand and deposited them in the house, and sent the men away and they departed.

When he went in and stood before his master, Elisha said to him,

"Where have you been, Gehazi?"

"Your servant has not been away anywhere," he said.

"Was I not present in spirit when the man turned from his chariot to meet you?" he said. "Is it a time to accept money, and garments, and olive orchards and vineyards, and sheep and oxen, and men-servants and maidservants? The leprosy of Naaman shall fasten upon you, and upon your descendants forever.

"So he went out of his presence, a leper as white as snow."

Now what can we glean from this account of a patient with psoriasis that will help us in the care of this papulo-squamous eruption?

First, the case report emphasizes the emotional and social discomfort that often accompanies skin diseases, especially psoriasis, and even in higher places it can effect politics and human relationships.

Secondly, let us not neglect "the laying on of hands," that is, touching, examining, and explaining to the patient about his skin disease, since this is of the utmost importance in getting the treatment done. Patients can and do get "exceeding wroth" over this neglect today.

Third, the treatment should be simple, but it must be stated positively, directly, and with authority. Let us not over-do our care with useless pills and injections. Sun exposure for a week at Miami Beach can be as useful as the seven day washing at the river Jordan was for Naaman.

Fourth, give God credit for the cure, but you take the cash. There would have been no thievery had this been done for Naaman. On the other hand, let us not be greedy, but consider the social and financial status of our patients.

Fifth, let us not discount the friendly poor—the little servant girl who is often the source of patients.



Let us then care for the poor as we do the rich.

Sixth, "Primum Non Nocere."

Let me quote from Dr. Iago Galdston's recent book, *Medicine in Transition*, "Above all 'to do no harm' is one of the hallowed principles of medicine. It is a precept that seemingly constrains but in effect inspires. For it is an exhortation to be judicious

rather than shallow, to be deliberate rather than precipitous, to be mindful of the whole no less than of the part, to be informed, intelligent, philosophical, and humble, as well as cautious where knowledge is limited and experience meager."

(The Biblical quotation was taken from The Complete Bible, An American Translation, J. M. Powis Smith and Edgar J. Godspeed, The University of Chicago Press, Chicago, Illinois. Eighteenth Impression 1964.)

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## '66 MEDICAL LEGISLATIVE ROUNDUP AT STATE CAPITOL

*From the standpoint of medical legislation, the 1966 Georgia General Assembly was the most active session of the State Legislature held in many years. More than 50 bills and resolutions covering a wide variety of subjects were introduced during the 40-day session at the State Capitol. The following report is a brief summary of the more important matters presented during the 1966 term.*

**Osteopathy:** The Osteopathic Association pushed two bills: H.B. 49, designed to give them full practice privileges; and H.B. 553, a bill to require a year's internship in osteopathic hospitals as a condition for licensure. H.B. 49 was defeated in the House Hygiene & Sanitation Committee and H.B. 553 was enacted.

**Podiatry:** There were also two podiatry bills—H.B. 216 and S.B. 101—designed to accomplish the same objective; namely, require Blue Shield to cover their services with all Blue Shield policyholders. In the House, H.B. 216 was defeated on the floor by a vote of 54 yeas to 101 nays. In the Senate, S.B. 101 was reported from Committee but taken off the Rules Calendar and therefore never called up for a vote on the Senate floor.

**Voluntary Sterilization:** MAG sponsored this bill which was authored by Dr. Charles Watkins, one of four physician members of the House of Representatives. This Act is purely voluntary and would apply only to married couples who request such procedure in writing. A consultation with one other physician would be required and the attending physician is given both civil and criminal protection from suit. This bill was enacted.

**One-Year Internship:** This bill also authored by Rep. Watkins, M.D., would require that applicants for full M.D. licensure must have successfully completed a one year's internship in a hospital in good standing with the State Board of Medical Examiners. The Board is given discretionary powers in those instances where a physician transfers from another State that does not require the same standards.

**Home Health Services:** A bill to permit the County Boards of Health to provide home health care services

in those areas where such is not otherwise available was enacted.

**Autonomous Mental Health Board:** This bill, S.B. 21, would have created a separate Mental Health Board with complete autonomy in all matters relating to mental health including the operation of all public facilities for this purpose. S.B. 21 passed the Senate but was killed in the House Rules Committee. An interim committee was created to study this matter and report back to the General Assembly next year.

**PKU Testing:** A bill to compel the State Department of Public Health to promulgate regulations requiring a test for phenylketonuria on all newborn infants (where possible) was enacted.

**Pay Patient—Family Responsibility:** As enacted this bill permits the Department of Health to change its method of charging patients in State institutions such as Milledgeville Hospital. Fees for professional services (as distinguished from hospital per diem) will be collected in the name of the treating physicians. This money will then be turned over to the State to be spent for training and research in the field of mental illness.

**Hospital Research Data:** Provides that any person or hospital may release data relating to condition and treatment of any person to research groups, medical societies and in-hospital staff committees for the purpose of conducting studies to reduce morbidity or mortality. The bill exempts from liability those who furnish such data provided the identity of patients is not disclosed.

**Two-Year Nursing Program:** Senate Bill 114 as enacted provides that graduates of two-year nurse training programs in junior colleges and universities (utilizing hospital and other clinical facilities) shall be eligible to take the State examination given by the Board of Examiners of Nurses for Georgia.

**Family Planning:** This act as passed authorizes the local and state Departments of Health, and Family and Children Services to provide family planning services, including the referral of service recipients to physicians for consultations, examinations, tests, treatment and prescriptions for the purposes of birth control, infertility and family planning.



# STRICTURE OF THE MALE URETHRA

Donald J. McKenzie, M.D., *Thomasville*

- While stricture secondary to infection has diminished, stricture following instrumentation has increased.

URETHRAL STRICTURE may result in dilatation and hypertrophy of the urinary bladder, eventual accumulation of residual urine, with subsequent chronic infection of the entire genitourinary tract. The stricture may mimic prostatism in the older age group and contracture of the vesical neck in the younger age group. It is now well recognized that there is no standard array of symptoms that are pathognomonic of any single obstructive entity distal to the bladder. Perhaps, more than any other single clue, the age of the individual is important in indicating urethral stricture. Although it has been estimated that it takes approximately 20 years for stricture to develop following gonorrheal urethritis, these individuals are commonly seen in the 35 to 45 year range. As the use of endoscopic instruments has increased, the incidence of stricture secondary to trauma from instrumentation has also increased. This, unfortunately, has significantly increased the incidence of stricture in the very young. As a result of this, numerous authors have pleaded for more conservatism in instrumenting the very young, especially male children.

The incidence of severe gonorrheal urethritis as a cause of stricture is probably on the decrease because of prompt recognition and intensive treatment with antibiotics, while the incidence of stricture secondary to instrumentation rises.

## Occurrence

Approximately 70% of inflammatory strictures occur in the bulbo-membranous urethra.<sup>1</sup> The pendulous urethra is next most commonly involved and the glandular urethra is least commonly affected. Traumatic occurrences with instruments have increased the incidence of urethral stricture at the meatus, pendulous urethra and vesical neck.

It is important to note that the finding of a significantly enlarged prostate gland by digital rectal

examination does not rule out urethral stricture as the primary cause of the obstructive symptoms.

The individual usually presents the physician with the primary complaint of decreased urinary stream velocity, progressive nocturia as the bladder now becomes incompletely emptied following each voiding, hesitancy, and dribbling following urination. It is not infrequent that these individuals are initially seen by urologists in the emergency room because of total urinary retention.

## The Procedure

The most innocuous and simple procedure is the passage of a soft catheter of approximately 16 to 18 French in diameter. The catheter in the presence of a bulbo-membranous stricture will encounter resistance that is obvious to the examiner as occurring more distally to the vesical neck, thus aiding in ruling out prostatism as the primary cause of obstruction. The next most common instrument used is the Otis Bulb or bougie a boule. This is an invaluable instrument for locating exactly the point of stricture. An urethrogram performed by injecting dye into the urethra is of assistance in visualizing the exact location, distance and extent of the stricture. Cystoscopy with direct visualization of the strictured area is, of course, useful both as a diagnostic aid and therapeutically in dilating the stricture.

As in treating any chronic disease, the treatment of urethral stricture requires the utmost patience on the part of the physician and extensive cooperation by the patient. A single overzealous dilatation by the physician can often reverse the patient's progress to a striking degree. As his symptoms improve with treatment, failure of the patient to return for periodic urethral dilatation causes an equally unfortunate reversal in progress.

The treatment of urethral stricture, as in the



## STRICTURE OF URETHRA / McKenzie

treatment of any other stricture in the urinary tract, is perhaps most poorly done by the simple process of dilatation. Strictures are treated and symptoms are relieved by the passage of instruments forcibly opening up this scarred-down area. It is not infrequently that the treatment becomes an integral part or factor influencing the chronicity of the problem of urethral stricture. As an instrument is passed of sufficient size to dilate the strictured urethra, small tears in the mucous membrane of the urethra occur. Subsequent minute urinary extravasation occurs in the periurethral area. There may be absolutely no local or systemic manifestations of this. However, this causes an intense periurethral inflammatory reaction with increased scarring as this inflammatory process heals, with further compromise of the lumen of the urethra. It is therefore of extreme importance to bear these things in mind when undertaking urethral dilatation.

### Some Surgical Success

Because of the deep frustration encountered by both the physician and patient in the treatment of urethral stricture, this problem has been approached surgically with some success. Primarily the strictured urethra, in severe cases, is not and never will be an adequate urinary conduit because of chronically occurring decrease in caliber. The answer, therefore, would be to eliminate the urethra entirely down to and including the strictured area. This area would then be left to heal openly by second intention. Following this, a new urethral tube would be constructed.

Johansen,<sup>2</sup> employing the principles developed by Duplay and Denis Browne, has devised such a pro-

cedure. The entire strictured area is excised openly and allowed to heal. Following this, employing the principle of burying intact a strip of epithelium, such as is used in the Denis Browne urethroplasties for hypospadias repair, a new urethral tube is constructed. In his series followed by urethrograms and endoscopy as well as timed micturition, Johansen was able to demonstrate significant improvement.

### Conclusions

Urethral stricture occurs quite commonly and is treated by a number of physicians other than urologists. The extent of successful treatment seems proportional to the degree of cooperation by the patient and the untiring and patient attention of the physician. It is proposed that this is a chronic condition, and with the standard methods of treatment, chronicity is inherent. Surgical procedures are available for the definitive treatment of urethral stricture. These are not quickly performed with excellent results. The urethroplasties require an extended period of time in which patient cooperation and physician skill and effort are maximal. The choice is not simply between chronic dilatations and urethroplasties. It would seem that the majority of cases of urethral stricture will be treated as they have been for decades—with periodic gentle dilatations, and with urethroplasties done in a selected group, depending on surgical feasibility and patient cooperation.

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818 Gordon Avenue

## BIRTH DEFECTS SPECIAL TREATMENT CENTER AT GRADY MEMORIAL HOSPITAL IS IN ITS THIRD YEAR OF OPERATION

Emory University's Birth Defects Special Treatment Center at Grady Memorial Hospital is in its third year of operation. The center, one of 47 in the nation, is supported by The National Foundation.

Since the center was established in January, 1963, more than 500 patients have been treated.

One of the landmarks in the center's history was the diagnosis in September, 1965, of the first and, apparently, the only known case of maple syrup urine disease in Georgia. The disease, a metabolic disorder, gets its name from the fact that the urine of its victims has the odor of maple syrup. If left untreated, it almost invariably causes severe mental retardation and, in some cases, death at an early age. The disease was first recognized in 1959. There are only about 40 known cases in the nation.

Patients treated at the center range in age from birth to 16 years. They are referred to the center by private physicians, public health nurses, or some medical agency.

The defects of most of the patients fall into one of the following categories: metabolic defects, spine and spinal cord diseases, muscle diseases, mental retardation of unknown cause, seizures, chromosome abnormalities with associated neurological handicaps, hydrocephalus and degenerative diseases of the nervous system.

The center has eight patients with phenylketonuria (PKU) on its rolls. This inherited metabolic disease is believed to be responsible for the brain damage and the resulting lower intellect of one in every 10,000 babies born in the United States.

The center's operating budget is about \$34,000 a year. Specialists in various branches of medicine and surgery are concerned with the center's work. The branches include orthopedics, urology, neurology, neurosurgery, physical medicine, and neuro-radiology. A psychologist and psychologist technician also work with the center.



# WHAT'S IN IT FOR YOU?

J. Frank Walker, M.D., *Atlanta*

## ■ The many services the AMA offers you.

**A** PHYSICIAN wishes to relocate his practice. He wants to consider all the important factors in choosing a new location. He turns to his AMA.

Another physician is preparing a clinical paper. He hasn't time to spend long hours in research. He turns to AMA.

Dr. Smith has been invited to form a partnership. Where can he get model agreements and other legal forms? Dr. Smith, also, turns to the AMA.

A quack has moved into the city and is doing a remarkable job of selling himself. A physician wants documented information on the man. *That* physician turns to the AMA.

### To Take Advantage

These people are taking advantage of just a few of the many services your American Medical Association offers to the individual member. These services are provided through the joint efforts of the more than 200,000 AMA members to their individual colleagues. You, and other individual members, are the AMA. You guide its activities through membership in your local medical society, one of the nearly 2,000 which make up 54 state and territorial medical societies. Your annual dues are \$45.00—2½¢ a day. They pay approximately 28% of the AMA working budget, with the remainder coming chiefly from the sale of advertising space in, and subscriptions to, its publications.

You govern your AMA through the 235-member House of Delegates, from your state societies, through the Board of Trustees, and Officers elected by the House.

### The Purpose

The purpose of the AMA is the same today as it was in 1847: "The promotion of the science and art of medicine, and the betterment of public health." This constant goal is sought in many ways: through public education, through scientific activity and through careful attention to the needs of the indi-

vidual physician. That attention comes from the AMA Headquarters Offices in Chicago, or from its smaller office in Washington, D. C. In the Chicago office, with 900 employees, the Executive Vice President oversees the day-to-day administration of your organization. Most physicians exhibit surprise when they learn that only 23 of the 900 employees are in the Washington office.

A great share of the duties of these people is the provision of individual services which are yours as a member of the AMA.

### The Legal Department

I mentioned the physician who sought legal help in establishing a partnership. He wrote to the office of the General Counsel. From this office, the member can have a selection of more than 50 pieces of literature, designed to guide one in the legal ways of medicine. (However, ethics forbids this Division from the dispensing of specific advice, of course.) The literature available ranges from model acts and agreements for incorporation, office rental or credit buying, to federal income tax guides, material on professional liability, consent to treatment, and general ethics. For the physician who wants to know more about professional liability, there is a one-year home study course called, "Legal Problems in the Practice of Medicine."

Still in the business of your professional duties, you may want to call our Department of Medical Finance for advice on such items as credits and collections, ownership, or rental of office space and the financial factors of private practice and partnership. Model business forms are available to aid you in your record keeping. Pamphlets include, "The Business Side of Medical Practice" and "A Guide to Establishing Medical Practice Units," both published in conjunction with the Sears Foundation. Another is, "Guidelines to Forming a Group Practice."

Through our physician placement service, we provide help to the graduate seeking the best place to open his practice, or to the physician who wants to relocate. He advises the AMA of his preferred loca-



tion, as well as his personal history and background. We then put him in touch with selected state placement agencies and provide him with a list of opportunities in all states. A pamphlet, "Finding a Place to Practice," explains the whole procedure and gives valuable suggestions on making the wisest choice.

Of equal importance in establishing or relocating a practice are reciprocity agreements. Your AMA Medical Education Department can give complete information. It will also supply data on licensure requirements, foreign graduate practices, special training programs and residency approvals.

### Research Done for You

Now that you have your practice humming, your county society has asked you to give a paper on some scientific subject. Your busy schedule does not permit you to spend a great deal of time researching, so you call or write the Medical Library of your AMA. Here, from more than 28,000 scientific books and 2,200 journals, the staff will do your research for you. It will examine and compile bibliographies from all current literature, and send you full copies of the pertinent material. If you wish, the library will loan you a package of literature for your use. This is the same library responsible for the publication of the annual "Cumulative Index Medicus," and "The Digest of Official AMA Actions."

You have a second library for your personal use as an AMA member. This is the Film Library in the Department of Medical Motion Pictures and Television. Here you can rent at nominal cost any of the 1,200 films on 258 medical subjects for professional or lay audiences. All current titles and reviews are sent to any AMA member on request. If the library does not have the film you want, its staff can tell you if one can be obtained elsewhere and how to get it.

### The Publications

When we stop to consider it, the periodicals which each member receives at no extra charge could, if paid for, cost as much or more than his annual dues. To begin, there is the weekly copy of the *Journal of the American Medical Association*. *JAMA* is recognized and read throughout the world as the foremost authoritative source of medical information. Its weekly circulation, in excess of 100,000, reaches more than 110 countries. Its scientific articles, news editorials, abstracts and socio-economic information are of interest and value to physicians everywhere. Clinical questions submitted by physicians are given to one or more recognized authorities to answer. If the question and its answers are not published in

the *Journal*, a personal answer is sent to the questioner. The editors of the *Journal* also publish the annual *Current Medical Terminology*, a valuable dictionary which sells for \$2.00.

In addition to his weekly copy of *JAMA*, every member is entitled to a choice of any one of ten monthly specialty journals. He may receive a free reception room copy of *Today's Health*, AMA popular monthly health and family magazine. Weekly, he receives the *AMA News*, to keep him current on socio-economic developments of importance in his practice and to bring him non-technical news of the medical community. The AMA is one of the world's largest publishing houses.

In addition to free entry to both of the major annual and clinical conventions, there is a free physical exam offered at the June session.

The Department of Drugs of the AMA offers immediate counseling on all drugs, a printed index of current drugs, and special reports on the current status of therapy and disease.

The physician who plans to speak to a lay audience on a socio-economic subject may receive model speech material, and there is a guide to speaking to a radio or TV audience.

If you need information to convince a patient or family of the dangers of trusting a local quack or his products, it is yours from our Department of Investigation. The AMA possesses the largest files in existence on the men and funny products which annually bilk the gullible out of one billion dollars.

To help you in the general area of patient contact, you have access to a number of excellent printed aids, including monthly health education posters, a fee plaque, and a booklet which has proved extremely successful as a guide for office nurses and receptionists, "Winning Ways With Patients."

### AMA-ERF

Because medicine needs good men and women, the AMA-ERF Student Loan program is important to you, and it needs your help. Through the program, students, interns, and residents may borrow up to \$1,500 in a 12-month period and up to \$10,000 in a seven-year period. In four years, the program has loaned over \$18,000,000 to approximately 18,000 deserving borrowers. However, the money can't be loaned until it comes in. Foundations, industry, professional groups, county and state societies, and individuals have been generous in helping to insure financial backing for deserving young men and women. Every dollar you contribute to this important fund enables a private bank to loan \$12.50 to a student.

If you are planning a trip abroad or thinking of a permanent foreign assignment, contact your De-



partment of International Health. It will give you information on foreign countries, medical facilities, physician ratios, disease statistics and even a list of foreign hosts for the visiting American physician.

**Your Insurance**

Your AMA membership provides a specialized service as an aid in building economic security for you and your family. This is the AMA Group Disability Insurance program, which offers life-time benefits for total disability due to sickness or accident. It is open to all eligible members of the AMA, except full-time members of the armed forces. Depending on the plan selected, the insured is given a choice of three different tax-free indemnity plans, paying \$1,000, \$750 or \$500 monthly, and these payments are for life, if total disability continues. This life-time quality is what makes the program unique. You can have complete information on this disability plan from the AMA Department of Medical Service.

There is the AMA member's retirement savings plan, a full-time retirement plan for qualified member physicians and their full-time employees. This plan, made possible by the passage of the Keogh Bill, provides both a valuable investment fund and annuity insurance. The contributor designates the proportion to be invested in both, which makes the plan singular, to the best of our knowledge. The lengthy explanation this plan needs is contained in the complete enrollment package, which is available through the AMA business division.

There is a new, nine-story Institute for Bio-medical Research adjacent to the AMA Headquarters Offices in Chicago. It is your building, an institute—visit it.

Your AMA functions through 13 Councils, 64 Committees and six Commissions, which are served by 800 physicians from all parts of the country, who serve without remuneration.

You are all familiar with AMA leadership in all

areas of medical education, including 17 residency review committees.

These are some of the special personalized services available to you through your AMA membership. They are services to make your practice easier and to keep you current on the progress of medicine. They are over and above those provided through your local state society. All are yours from your AMA.

The purpose of the AMA is the same today as it was in 1847, when there were 29 states, when James Pope was our eleventh President, when the first U. S. postage stamp was being printed, and when Charles Dickens sat down to write *David Copperfield*—"The promotion of the science and art of medicine and the betterment of public health."

**What Kind of an AMA Member Are You?**

Are you an active member, the kind that would be missed,  
Or are you just contented that your name is on the list?  
Do you attend the meetings, and mingle with the flock,  
Or do you stay at home, then criticize and knock?  
Do you take an active part to help the work along,  
Or do you think it good enough to merely belong?  
Do you ever volunteer to help the guiding stick,  
Or leave the work to just a few and talk about the clique?  
Come to the meetings often and help with hand and heart,  
Don't be "just a member" but take an active part,  
Think this over—you know right from wrong,  
Are you an active member—or do you "just belong"??

**QUERIES ON NEW MEDICARE  
LAW ARE ANSWERED**

*Excerpts from questions posed by physicians in attendance at the MAG County Medical Society Leadership Conference, February 5, 1966, as answered by representatives of the Social Security Administration on the new "Medicare" law, P.L. 89-97.*

(4) *Will the post-hospital home health care provisions under Part A pay the physician's fee?*

No. Physicians' services are covered under Part B.

(6) *Who decides on the acceptability of the utilization review plan?*

The State agency will recommend to the Secretary those hospitals having a utilization review plan that meets the basic legal requirements of the law.



# For Your MAG 1966 Annual Session Hotel & Motel Reservations

## APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS Medical Association of Georgia 112th Annual Session May 8-10, 1966—Columbus, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Columbus for the 1966 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodation information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure; (3) names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Housing Bureau. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible to secure the accommodations you request. All reservations will be confirmed.

**Ralston Motor Hotel, Inc.:** 12th Street and 2nd Avenue (322-7331) 250 rooms; **Single \$6 to \$8; Double \$8 to \$10; Twin \$9 to \$12;** air conditioned; television and background music; Coffee Shop and Dining Room—open 6:30 A.M.-11:00 P.M.; Chart Room Lounge for Lunch and Beverages—open 11:00 A.M.-1:00 A.M., downtown Columbus.

**Martinique Motor Hotel:** 1011 4th Avenue (322-6641) 198 rooms; **Single \$8 to \$10; Double \$11 to \$13; Twin \$13 to \$16; Deluxe Studio Rooms \$13 up;** air conditioned; background music; TV in every room; room telephones; two restaurants; swimming pool; Grand Prix Lounge; package store on premises; barber shop; valet laundry service; downtown Columbus.

**Downtowner Motor Inn:** 1325 4th Avenue (322-2522) 99 rooms; **Single \$8 up; Double \$10.50; Twin \$12; Suites \$18 up;** air conditioned; background music; TV in every room; room telephones; 24 hour switchboard; restaurant 6 A.M. to 10 P.M.; swimming

pool; steam room—massuer; Boar's Head Lounge; package store on premises; downtown Columbus.

**Heart of Columbus Motel, Inc.:** 1024 4th Avenue (324-3694) 42 rooms; **Single \$7; Double \$9; Twin \$11;** air conditioned; room telephones; adjoining restaurant; TV in every room, downtown Columbus.

**Holiday Inn of America:** 3170 Victory Drive (689-6181) 184 rooms; **Single \$7 and \$8; Double \$9.50; Twin \$11 and \$12.50; Executive Room \$12.50;** air conditioned; TV in every room; background music; room telephones; restaurant; swimming pool; 3 miles from downtown Columbus.

**Howard Johnson's Motor Lodge:** 3181 Victory Drive (689-7580) 50 rooms; **Single \$9 and \$10; Double \$10; Twin \$12; Family Units \$14 to \$16;** air conditioned; background music; TV in every room; room telephones; lounge; swimming pool; putting green; Howard Johnson's Restaurant next door; 3 miles from downtown Columbus.

*Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made. Deposit of one day's room rent will be required with each request for accommodations.*

Cut out and send to:

Please Type or Print

HOUSING BUREAU, MEDICAL ASSOCIATION OF GEORGIA

Ralston Motor Hotel, Columbus, Georgia

Please reserve the following accommodations for the 1966 Annual Session of the

Medical Association of Georgia.

Hotel or Motel Preference

1st Choice

2nd Choice

3rd Choice

Arrival Date

Departure Date

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include all names of all persons for whom you are requesting reservations and who will occupy the room(s):

Name of Occupant(s)

Address

Individual Requesting Reservations

Name

Address

City

State

Zip Code

☐ Double Room at \$..... to \$.....

☐ Double Room at \$..... to \$.....

☐ Twin Bedroom at \$..... to \$.....

☐ Other Type .....

Hour.....A.M.....P.M.

Hour.....A.M.....P.M.

If hotels or motels of your choice are unable to accept your reservations, the Housing Bureau will make reservations to fit your specifications elsewhere.





## For Services Freely Given . . . . .

THE PHYSICIAN is often confronted with the accusation that he does not take the lead in health affairs affecting the public and that he has no one but himself to blame if a benevolent government steps in.

This accusation stems in part from the fact that the physician adheres to a code of ethics which inhibits his voluntarily stepping forth as an expert.

But it also stems partly from the fact that the public is often unaware of the contribution he does make.

The gold medallion on the cover of this issue calls attention to one service the physicians in Georgia have been voluntarily giving for the past 17 years. More than 200 physicians and surgeons—cardiologists, internists, pediatricians, radiologists, and doctors in general practice—give more than 10,000 hours of professional time each year to serve as many as 30,000 indigent patients in 14 clinics sponsored by the Georgia Heart Association.

The Georgia Heart Association has chosen to recognize publicly the services rendered by these physicians.

The Medical Association of Georgia joins in extending to them its congratulations and its appreciation for the leadership and contributions they have given. They have donated a service not only to the patients who have benefited, and to the communities they serve, but to the entire medical profession.

*M. Linwood Beck  
Executive Director  
Georgia Heart Association  
Atlanta, Georgia*

## The Emerging Citadel\*

FOR YEARS MANY doctors have had strong misgivings about the real objectives of the American Hospital Association. Representatives of the AHA have always denied that their purposes were anything but the preservation of the system that has furnished high quality, effective health care to the American people. Now, however, the dissimulation has ended, and the hospital administrators have clearly stated their ambition to control every facet of medical service available to the public.

*A Statement on the Changing Hospital and the*

\* Reprinted with permission from the Wisconsin Medical Journal 64:419, October, 1965.

*American Hospital Association*, recently adopted by the AHA, spells out the master goal of the organization. No longer is the hospital to be a facility for the care and treatment of the sick by physicians and surgeons. In the AHA vision, the hospital is the "citadel of medical services in modern society." It is to be "an organized arrangement of all medical resources necessary to bring the individual, wherever located, into contact with the skills of his physician and other members of the health care team." It is to be the health care instrumentality of the community (read government), the exclusive source of all medical service to the individual. It is even to



embrace with its tentacles such non-hospital functions as school health programs, visiting nurse services and other preventative, curative, and rehabilitative health services. The entire spectrum of health care—the richly developed, highly refined expression of the finest ideals of an enlightened, altruistic society—is now to be made the power tool of the hospital administrator.

To be sure, the *Statement* recommends that the physician be “increasingly involved in the organizational workings of the hospital.” Taking its simile from another area of make-believe, the AHA believes that doctors must be given “the opportunity and the responsibility to help write the organizational script as well as act from it.” But presumably the hospital administrator will direct and produce the drama as well as sit in the box-office and sell the tickets of admission. Doctors will no longer retain their professional independence nor their integrity; under the AHA plan they will be “involved” in the “citadel.” As individuals, they will be subordinate to the organization which has subsumed all health care functions.

Make no mistake about it, the issue is control of the medical profession. At stake is not only the freedom of individual practice but also the continued control of health care services by qualified medical personnel rather than administrators.

### Joined the Ranks

After many years of paying lip service to the cause of free medical practice, the AHA has openly joined the ranks of those who would extend federal control over every facet of health care. In its *Statement* the AHA claims to recognize that most health care is paid for either by insurance companies or the government, who are sophisticated “purchasers” of service, “not merely passive payers for services. They are properly insistent upon prudent management of hospitals and upon guarantees that the available health resources of all kinds—money, people and facilities—be used efficiently and effectively.”

And who is to see to it that the available health resources are used efficiently and effectively, according to the desires of the highly sophisticated “purchasers”? Why, the hospital administrators—that’s who. And so the knot is tied and the health care package is delivered, gift-wrapped and be-ribboned, to the federal bureaucrats by the hospital administrators.

### Abdication of Responsibility

Chilling as it is to contemplate, the scheme is unfortunately a logical conclusion of present trends. For reasons of convenience, many doctors have abdicated their responsibilities to the hospitals with which they are associated. They have permitted hospitals to assume an unwarranted importance in their own practices; they have often made heavier use of hospital facilities than necessary. If doctors are to preserve their independence as scientists and practitioners, we must make an energetic, planned effort to retain control of our medical activities. We must refrain from seeing patients in hospitals when they can be seen in our own offices at less cost and greater convenience to the patient. We must make greater use of non-hospital laboratory facilities when available, often at less cost to the patient. And we must not submit to any effort to reduce us to the status of pawns under the direction of a hospital administrator.

Before the hospital administrator becomes entrenched in his “citadel,” local medical societies must take a firm position against any implementation of the AHA plan for capturing the national medical environment. Vigilance, foresight, and concerted action on the part of organized medicine is required, and the battle must be fought and won on a community level. Now that the AHA has defined its position, the medical profession knows where the danger lies. We must overcome it vigorously. If we back off this time, we lose our professional independence.

D. N. Goldstein, M.D.\*\*  
723 Fifty-eighth Street  
Kenosha, Wisconsin

\*\* Dr. Goldstein is a General Practitioner and a member of the A.A.G.P. He practices in Kenosha, Wisconsin, and is the Editorial Director of the Wisconsin Medical Journal.

## Why Change?

THE PHYSICIANS in Georgia and throughout the United States who specialize in Radiology are in the process of separating their professional practices from the growing pool of hospital services. They are determined to conduct their practices in a manner

similar to their fellow physicians, by establishing an ethical and direct physician-patient relationship for the betterment of patient care, diagnosis, and therapy. In all respects they want to be on the same footing—no more, no less—with physicians practicing in



other branches of medicine in the traditional American concept of practice. In order to attain their rightful and ethical professional status, they must terminate existing percentage-type contracts with hospitals and submit their own statements directly to patients to whom they supply their professional services. For many years, Radiologists have unfortunately allowed themselves to become a part of a relationship in which hospitals bill for their services as part of a combined hospital bill to patients served in hospital Radiology departments. The convenience of this arrangement masked the subtle, but very definite, change by which these physicians' services came to be dominated by hospital officials and to be identified as a hospital service rather than a medical service.

### A Complex Answer

Physicians other than Radiologists have asked, "Why change?" from this convenient arrangement. Some feel that Radiologists are in an enviable position in that they don't have to be concerned with the business side of practice. Some of them wonder whether a Radiologist is making a wise decision in divorcing himself financially from the hospital. The answer to the question, "Why change?" is a complex one dealing specifically with the future of Radiology as a medical speciality, and generally with the future of all physicians engaged in the American system of the practice of medicine.

Last year, Radiologists were threatened with a severe blow to their professional freedom when the U.S. Congress attempted to classify the practice of Radiology as a hospital service. However, despite protests from the American Hospital Association, Congress correctly classified the practice of Radiology as a medical service in P.L. 89-97, to be paid for under part B—the medical insurance portion, as are the services of other physicians. This threat to the future of Radiology, and the continuing efforts to amend the law to include these and other physicians' services as hospital services, have given Radiologists a focal point around which to strive for the emancipation of Radiology from hospital and governmental domination. Other physicians will undoubtedly have their professional freedom threatened as present socialistic trends continue. The current efforts of Radiologists may be considered as one of the early phases in a continuing struggle for professional freedom in which other physicians will become involved in the not too distant future. In countries which have socialized their medical professions, Radiology and Pathology were among the first to go, followed thereafter by Surgery, Internal Medicine and all branches of medicine. On page 145 in this issue of the *JMAG* there is a highly informative editorial entitled, "The Emerging Citadel." Please Doctor, read this editorial

carefully and wake up before it is too late! Hospital based physicians are usually more aware of the definite dangers pointed out in this editorial than other physicians, since they are more constantly exposed to the dictates of organized hospital administration.

### Growing Number of Abuses

The usual contracts entered into between Radiologists and hospital officials have caused a growing number of abuses and conflicts. Such contracts may contain discriminatory restrictions not required of other physicians, such as forbidding the Radiologist to have a private office in the same town as the hospital. This type arrangement allows the hospital administrator to substitute the goal of hospital profit rather the goal of attaining a Radiologist with the most professional experience and competence. He will shop around trying to obtain a Radiologist who will accept the lowest possible percentage, thereby, enabling the hospital to make the largest possible profit. This extra profit is not passed on to the patient as a reduction in x-ray charges. Percentage contracts place radiologists in the unpleasant position of trying to underbid their fellow specialists for the privilege of practicing Radiology in a restricted hospital department. Such contracts tend to identify the Radiologist as a hospital employee rather than as a physician. As the number of patients examined in the hospital x-ray department increases, the hospital begins to encroach on the Radiologist's professional component, so that this additional profit can be used in other departments of the hospital. Hospital officials do not consider this fee-splitting, and this encroachment usually occurs when the extra income is most needed to obtain additional Radiologists to help maintain quality Radiology as the patient load increases. Existing contractual arrangements are therefore not conducive to the optimum quality of radiologic service or to the optimum number of qualified Radiologists which may be needed in a given hospital. Such contracts allow hospital officials to terminate the agreement and to try to fire the Radiologist for unjustified reasons. Specific examples of these and other unfortunate abuses are present in Georgia today.

### In Conflict

The pooling of the Radiologists' professional fees with the hospital service charges conceals from the patient how much of his bill is to be paid to the physician. The patient has a right to know how much he is paying his physician. This aspect also causes confusion among health insurance companies in trying to determine what portion of the x-ray charge is a physician's fee and what portion is the hospital service charge; and this in turn has compounded the



problem even further by forcing the insurance companies to include hospital-based physicians' fees in hospital service contracts rather than medical service contracts. The practice of allowing hospitals to sell physician services for a fee is in direct conflict with the laws of the state of Georgia and with the Code of Ethics of the American Medical Association. The inclusion of Radiology benefits in hospital insurance contracts has encouraged the practice of patients being admitted to the hospital for radiographic examinations. Most of these could be just as adequately performed on an out-patient basis either in the hospital or in the private office of a Radiologist at even less cost to the patient. This has resulted in the overcrowding of hospital beds and an unnecessary increase in premiums for hospital insurance.

Another answer to the question "Why change?" is that existing arrangements with hospitals tend to frighten away promising young physicians who might otherwise be recruited into Radiology. Only 75% of the approved residencies in Radiology are filled at the present time. It is estimated that we are now short 1,000 qualified Radiologists in this country. Unless Radiology can compete with the other branches of medicine and offer professional freedom to its recruits, this shortage will grow more acute and the future of quality Radiology will indeed be very bleak.

### The Clearing House

For many years, the American Medical Association, The American College of Radiology, The Medical Association of Georgia, The Georgia Radiological Society, and other organizations have served as clearing houses for the growing number of complaints arising from financial contractual arrangements between hospitals and Radiologists. These organizations are more aware of the need for changing existing

patterns than are some individual Radiologists. Because of this, these organizations have for many years strongly opposed the sale of physicians' services by hospitals, and now they have taken a united front in strongly urging Radiologists to completely divorce themselves financially from hospitals and to practice medicine and bill their patients directly in the same manner as other physicians have always done. The nation's hospital Radiologists are now striving to make an orderly transition from the unfortunate system of merged billings to a proper and ethical arrangement in which the Radiologist submits his bill directly to the patient, and the hospital submits a separate bill for its service charge. Such separate billings are required for beneficiaries of P.L. 89-97. The transition to separate billing will not be an easy one. Georgia Radiologists have already met opposition, and will encounter more resisting pressures in many cases from organized hospital administrations. It is anticipated that separate billing will remove the main cause of conflict between hospital officials and hospital based physicians, so that hospital administrators and Radiologists can work more harmoniously to achieve the best possible care for each individual patient.

Radiologists are promoting an ideal of ethical medical practice and hope to remove the taint of fee-splitting from their ranks. This ideal is important not only to Radiologists but to every practicing physician. It is hoped that the above has answered the question, "Why change?" and that each of you as a member of the MAG will continue to understand your Radiologist and support him as he attempts to obtain professional parity with his fellow physicians.

*Donald R. Rooney, M.D.  
President, Georgia  
Radiological Society  
Burnt Hickory Road  
Marietta, Georgia*

## ANNUAL AWARD CONTEST ANNOUNCED IN PSYCHOSOMATIC MEDICINE FIELD

The Academy of Psychosomatic Medicine announces the Annual Award contest for the best paper (not over 4,000 words) on a clinical or research subject in the field of psychosomatic medicine.

The winner will deliver his paper at the Thirteenth Annual Convention of the Academy of Psychosomatic Medicine in Las Vegas, Nevada, December, 1966, and the paper will be published in *Psychosomatics*, the official journal of the Academy.

The winner's travel expenses will be paid to and from the meeting. The committee reserves the right to submit all articles including the winning entry, to *Psychosomatics*, the official Academy journal. Manuscripts not

accepted for publication by *Psychosomatics* will be returned to their authors.

Members of the Annual Awards Committee are:

Wilfred Dorfman, M.D., Brooklyn, N. Y.  
F. P. Rhoades, M.D., Detroit, Mich.  
Benjamin Schneider, M.D., Danville, Pa., Chairman  
John J. Schwab, M.D., Gainesville, Fla.

The deadline date for submission of manuscripts is August 1, 1966.

For full particulars write to Benjamin Schneider, M.D., Chairman, 123 E. Market Street, Danville, Pennsylvania.





## "All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

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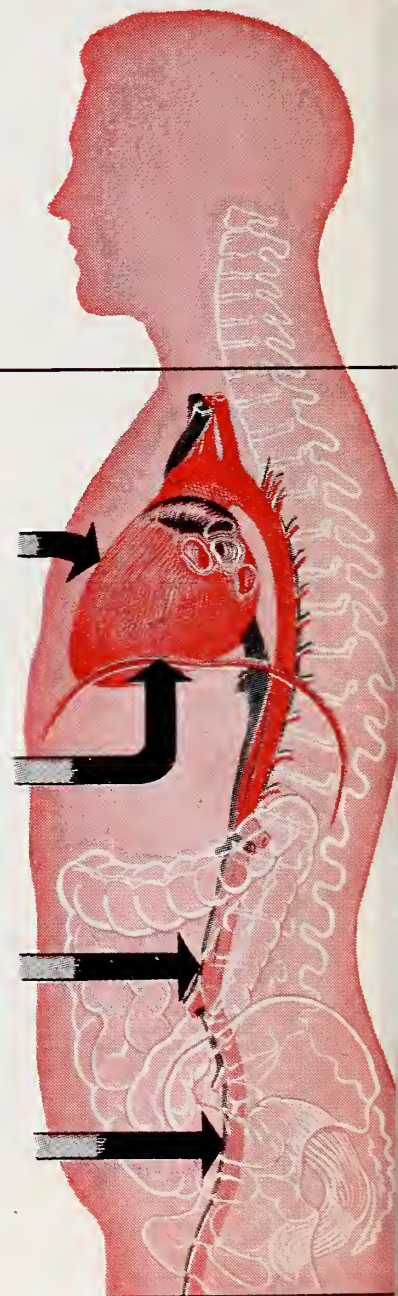
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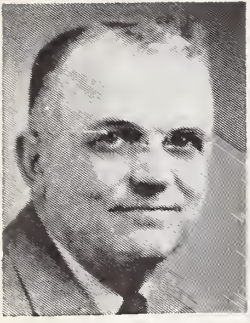
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## PRESIDENT'S LETTER

# THE PASTURE DIMLY SEEN

IT IS HOPED that Francis Scott Key, were he living, and one of our former governors might forgive me for the last two words of the title which I have chosen.

As we are approaching the end of this year for the Medical Association of Georgia—since last May when I took office—it is my feeling that it is both a time for looking forward and for looking back. As I look back, I see a number of things—both good and/or pleasant and the opposite.

### Of the Coin

The question might be asked as to what has occurred on each “side of the coin.” I think it is impossible to completely separate the two—sometimes the coin has been spinning so that an admixture has been produced.

The year now drawing to a close has been a period involving many problems, many decisions and many hours, not only by the President and Executive Committee, but by the other Officers, Council members, Committee members and the Headquarters Staff. Much travel has been necessary.

In some of the situations presented we have won and in some we have lost, but whenever it has been necessary to take a position, we have tried to take the right one.

The reports of Officers and Council—Council in particular—will go into more detail of the year's events, as this letter is not the right place for details.

For me there have been many rewarding experiences. These experiences have involved not only

travel but the meeting of many interesting people and the attendance at many informative meetings.

### An Age of Transition

As Adam is said to have said to Eve as they left the Garden of Eden: “Darling, we are in an age of transition.” I don't think by any stretch of the imagination that it could be said that we have been in a “Garden of Eden,” nor could it be said that we are about to enter one. I do feel, though, that we are being swept into a period which the medical profession will like less than the one we are leaving behind.

Walter Brown, your incoming President, is going to have many more difficulties than I have had, and they probably will be increasing from year to year for succeeding Presidents. Please stand ready and willing to give such help as may be needed and for which you will be called upon.

In the light of the foregoing the “dimly seen pasture” is intriguing. It is my hope that when my additional time on Council is over, I will be ready to enter the “pasture” without regret concerning the part I have played. I feel sure that those on the “other side of the fence” will carry on the cause of private medical practice in such a manner as to reflect credit upon the profession and the association.

*George H. Alexander, M.D.*

*President, Medical Association of Georgia*



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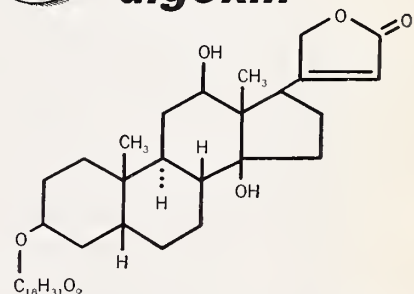
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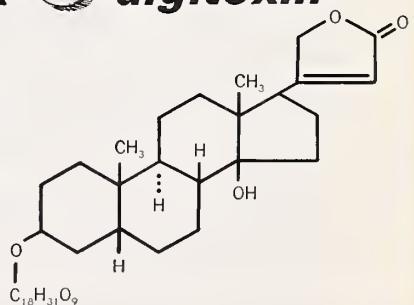
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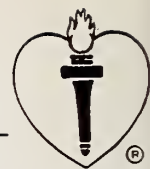
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## CURRENT THOUGHTS ON DIURETICS FOR CONGESTIVE HEART FAILURE

Alexis H. Davison, M.D., *Atlanta*

**A**LTHOUGH DIURETICS are employed in a wide variety of conditions from premenstrual tension to acute renal failure, they are most commonly used in the control of congestive heart failure. Most work by increasing the excretion of sodium by the kidney.

### Mercurial Diuretics

Until 1950, organic mercurials were the only diuretics available. Mercurials block the re-absorption of  $\text{Na}^+$  in the proximal tubule of the kidney. These are still the most potent diuretics currently available for general use. Problems that occur are hypovolemia from rapid diuresis (postural hypotension, cerebral thrombosis), digitalis intoxication from  $\text{K}^+$  loss and occasionally acute renal failure with frequent doses in patients with renal disease.

### Thiazides

Thiazide diuretics, in use since 1950, although less potent than mercurials, have the advantage of being effective orally and of having no renal toxicity. The plethora of products marketed all work in the same way by blocking  $\text{Na}^+$  reabsorption in the proximal tubule of the kidney. They differ only in dose and duration of action. Thiazides raise the serum uric acid and may precipitate gout in patients with hyperuricemia. Blood sugar may rise. Recent studies indicate that this may be a manifestation of  $\text{K}^+$  depletion. Chronic use may lead to  $\text{Na}^+$  and  $\text{K}^+$  depletion and/or metabolic alkalosis.

### Spironolactone and Dyrenium

These drugs work by interfering with the action of aldosterone on the distal tubule, i.e., they block the exchange of  $\text{Na}^+$  for  $\text{H}^+$  and  $\text{K}^+$ . Since  $\text{Na}^+$  must first be delivered to the distal tubule, they are best used in conjunction with thiazides or mercurials.

It must be remembered that these drugs prevent  $\text{K}^+$  loss and supplemental  $\text{K}^+$  is not needed. Dangerous levels of serum  $\text{K}^+$  have been seen even without supplemental  $\text{K}^+$ .

### Ethacrynic Acid

This drug has been undergoing clinical trial and may soon be available for general use. It is effective orally and parenterally and is more potent in maximal dosage than mercurials. Site of action is in the proximal tubule and ascending Loop of Henle. The primary danger of this compound is also its chief advantage—potency and rapidity of action. Large losses of  $\text{Na}^+$ ,  $\text{K}^+$ , and  $\text{H}^+$  may occur with severe hypovolemia, hypokalemia, and alkalosis. This drug will have to be used with care and discretion. Its characteristics make it very useful in the treatment of acute pulmonary edema and resistant edema states.

We cannot discuss diuretics without considering  $\text{K}^+$ . With diuresis  $\text{K}^+$  replacement is frequently indicated. Tablets with  $\text{KCl}$  have been implicated in small bowel ulceration with perforation and obstruction. Many feel that  $\text{K}^+$  supplement can be more safely administered in liquid form. Alkalosis may accompany hypokalemia. This is related to  $\text{Cl}^-$  loss and must be corrected with  $\text{Cl}^-$  as well as  $\text{K}^+$  repletion, i.e.,  $\text{KCl}$ . Many  $\text{K}^+$  supplements are alkaline salts of  $\text{K}$  and contain no  $\text{Cl}^-$ . They will correct neither the alkalosis nor the  $\text{Cl}^-$  deficit.

The physician's tool is often a double edged sword. Judiciously used, diuretics will bring comfort to many patients. Knowledge of the physiology involved and attention to detail is mandatory to prevent our doing harm.

36 Butler Street, S.E.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.





## RESISTANCE—A LAYMAN'S VIEW

Ruth S. Inglis, *Marietta*

**“W**HO ME? Go to a psychiatrist? I'm not crazy!”

This is a basic reactive attitude, very prevalent, very contagious. If a person recognizes that he might benefit from psychiatric counseling and might desire to seek it, and even though he knows he is not crazy, he must evaluate the risk involved in the reactions of his friends and associates. An individual may indeed be “sick” enough to need professional help, but he will be deterred from consulting a psychiatrist as long as the lay mind continues to equate “sick” with “crazy.”

### Fear to Reveal

“If I knew a psychiatrist I could trust, I'd consult him.”

This statement is not so much a reflection on the profession as it is evidence of the deep-seated fear in each of us to reveal the self to another. Schweitzer has said, “there is a modesty of the soul which we must recognize, just as we do that of the body.” In seeking help from a psychiatrist, a person would have many fears and doubts since such help involves consent to explore the thoughts, feelings and privacy of the person. He might also be fearful that a psychiatrist could confuse, misdirect or mislead him. It is probably true that most people know of more unsuccessful cases than successful ones because dissatisfied patients (or their families) are more vocal than persons who have been helped by psychotherapy.

### Quick Results Desired

The twentieth century American wants to “get results,” the sooner the better, and is not likely to accept the long-term involvement that psychotherapy demands. The results of psychotherapy are seldom dramatic and never quickly achieved. The most difficult aspect of therapy is “sticking with it.” One's own misgivings, attitudes of friends and family, guilt feelings about the cost involved, embarrassment that one is incapable of handling his own problems and many other factors make it difficult for an individual to continue a long course of therapy.

Religious attitudes are often basic in patterns of resistance but are too involved for discussion in this brief essay. Suffice it to say that attitudes in this area are, in some instances, almost medieval, although some enlightened members of the clergy are establishing dialogue with the psychiatric profession. To the average layman there is no insight whatsoever that there could be anything relative to Christianity in the realm of psychotherapy.

### The Silence

The area of non-verbal resistance, though intangible, is nevertheless real and is very often evidence of deeper resistance than that which is vocal. It is difficult to describe what is verbally omitted, but it is well illustrated in situations where a person avoids mention of treatment, neglects to inform relatives that psychiatric help has been sought, evades a simple acknowledgment of having an appointment with a psychiatrist in declining a conflicting invitation, etc. Possibly the most negative effect of this “silent resistance” is that it tends to intensify or underscore the aforementioned areas of resistance.

What might be labelled “average resistance” disappears in two situational extremes. At one extreme is the area in which psychiatric help is accepted (or sought) as a last resort; when problems have erupted into uncontrollable situations and hospitalization or emergency care are mandatory. At the other extreme “resistance” dissolves where psychiatric consultation has become over-accepted; “the thing to do,” “chic,” “status symbol.” This extreme is as unhealthy as the other.

Wherein then lies the desirable or healthy acceptance of psychiatric care or consultation? The answer is not simple but must be sought by professional and lay persons alike if preventive and curative psychiatry is to make any real strides in the near future.

*1611 Sheridan Drive*

Prepared at the request of the Sub-Committee on Mental Health of the Medical Association of Georgia.





## VOLUNTARY STERILIZATION

John L. Moore, Jr., *Atlanta*

**T**HIS SUBJECT has been discussed in the Legal Page of this magazine in the November, 1956, issue and in the September, 1960, issue. Recent requests for information on the subject correspond with the passage of House Bill No. 60 at the 1966 General Assembly. The Act, now known as Act No. 534, was signed by the Governor on March 10, 1966, and became effective that day.

### 1966 Act

House Bill No. 60 as passed in the House makes it lawful for any physician or surgeon licensed to practice medicine and surgery pursuant to the provisions of Chapter 84-9 of the Code of Georgia (such a license is a prerequisite to membership in The Medical Association of Georgia) to perform a voluntary sterilization procedure on a man or woman if the following steps are all taken:

1. The patient must be legally married (if there is any doubt, the physician should require an opinion of legal counsel that the patient is legally married).

2. A written request must be made by the patient and by his or her spouse to the physician asking for the performance of a sterilization procedure.

3. A full and reasonable medical explanation must be given by the surgeon to perform the operation to the patient and to the patient's spouse. It is suggested that the physician have a written explanation. He should discuss the matter orally with the patient and the patient's spouse, taking care to cover every point in the written material and any other points raised by the patient or the spouse. It is suggested that the physician obtain the signatures of the patient and spouse on a copy of the written form stating that the physician has covered the points in the form and answered questions raised by them and further that the patient and his spouse understand that after the sterilization procedure the couple will not be able to have children.

4. There must be a written consultation agreement from one other physician or surgeon licensed to practice medicine and surgery pursuant to the provisions of Chapter 84-9. Such consultation agreement must, of course, recommend that the performance of the named procedure on the named patient is in the best interest of that patient and his or her spouse.

5. The consultation agreement, the written request of the patient, and the consent of the spouse must all be attested to before a notary public.

If the preceding conditions have been satisfied, the surgeon may perform any "sterilization procedure." That term is defined in the Act to cover any "procedure or operation which is designed or intended to prevent conception and which is not designed or intended to unsex the patient by removing the ovaries or testicles."

Of course, the Act provides that the procedure must be performed by a doctor of medicine duly licensed to practice medicine and surgery.

### No Liability

The Act goes on to say that when any operation is performed in compliance with the provisions of the Act, there is no civil or criminal liability of the operating surgeon or any other person legally participating in the execution of the provisions of the Act except in the case of negligence in the performance of the procedures. It is further provided that nothing in the Act is to be construed to require compliance with the Act where medical or surgical treatment for sound therapeutic reasons of the patient may incidentally involve the nullification or destruction of the reproductive functions. For example, removal of certain sexual organs because of the presence or feared presence of cancer would not require compliance with all the routine described in the Act and in this Article. However, again, it will be wise to create written evidence of consent to a named procedure which consent makes it clear that the patient understands that the treatment may incidentally involve the nullification or destruction of



the reproductive functions for sound therapeutic reasons.

Before the enactment of House Bill No. 60 into law, there was no specific Act on the law books of Georgia covering the performance of voluntary sterilization procedures. There had been no cases on the subject in Georgia although there had been a few cases in other states all indicating that sterilization procedures were not against public policy provided there was sound medical opinion that a subsequent pregnancy might endanger the health or life of the wife. Under House Bill No. 60, it is not necessary to have such an extreme situation, and the sterilization procedures may presumably be used for family planning provided, of course, two physicians agree that the procedure is in the best interest of the husband and wife.

Incompetents

It should be emphasized that House Bill No. 60 deals only with legally competent, adult, married

persons. There is no provision in law whereby a private physician may perform a sterilization procedure on a child or a person who is not mentally competent. Further, there is no provision for performing such a procedure on an unmarried person or a person contemplating marriage who has not been married. The Eugenic Sterilization Statute remains on the books and, to the extent that the Eugenics Board approves performance of such procedures, they may be performed upon persons in state institutions. However, the Eugenic Sterilization Act only applies to persons whose mental condition or disease gives rise to the possibility that offspring will be mentally or physically defective.

It is, therefore, strongly recommended that physicians in Georgia not perform procedures on children, unmarried persons, or mentally incompetent persons except strictly pursuant to an order of the Eugenics Board.

Suite 1220  
C & S Bank Building

*Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.*

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\*Marks, V., and Dawson, A.:  
Brit. M. J. 1:293, 1965.

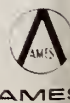
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**REFERENCES:** 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

\* This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

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## ABSTRACTS BY GEORGIA AUTHORS

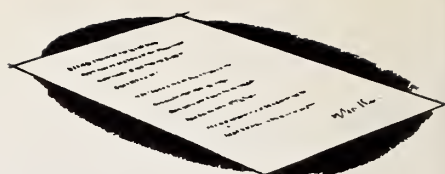
Birch, Herbert W., M.D., Dept. of OB-GYN, Emory Univ. School of Medicine, Atlanta, Ga., "Premalignant Lesions of the Vulva," *Southern Medical Journal* 58:1487-1492 (December)1965.

For a lesion of the vulva to be considered premalignant it must demonstrate a decided inclination toward going on into a cancer. White lesions of the vulva are the most important types of premalignant lesions. Any white lesions of the vulva should always be biopsied because it may in fact already be a pre-invasive malignant lesion such as carcinoma in situ, Bowen's disease, or Paget's disease. Leukoplakia is a white lesion and can proceed to cancer. If careful multiple biopsies are done and dysplasia is found, a vulvectomy is indicated. If there is no dysplasia, conservative management will be better and the biopsies would need to be repeated from time to time. Granulomatous venereal diseases provide the backdrop for a goodly number of carcinomas of the vulva. Patients with active disease or those with old residual scars need careful follow-up and biopsies. Vulvar condyloma generally do not proceed into carcinoma, but occasionally they can; therefore when condyloma fail to re-

spond to medical treatment, biopsy is indicated. Vulvar nevi should be removed because the majority of them are compound or junctional nevi and could go on into melanoma. There is an association between cancer of the vulva and diabetes so that patients that have a malignant or premalignant lesion of the vulva should be screened for diabetes and patients with diabetes should be followed a little more closely for the possible development of carcinoma of the vulva.

Yeh, Thomas J., M.D., and Robert G. Ellison, M.D., Medical College of Georgia, Augusta, Georgia, "Thrombotic Complication of Superior Vena Cava to Pulmonary Artery Anastomosis," *J. Thoracic Surg.* 50:571-574 (Oct)65

Superior vena cava to pulmonary artery anastomosis has been employed at the Medical College of Georgia in 18 cases (five patients under two years, two patients under six months) for palliation of cyanotic congenital heart defects such as tetralogy of Fallot or tricuspid atresia. Two patients had thrombotic complications, the only serious morbidity in this series. One was relatively mild and involved peripheral veins. The other was more severe and



resulted from thrombotic emboli obstructing the vena cava-pulmonary artery anastomosis. Both were managed successfully, the former conservatively with anticoagulant therapy and the latter with emergency thrombectomy. The technique of thrombectomy is described.

Van Duyn, John, M.D., Doctors Building, Columbus, Georgia, "Psyche and Plastic Surgery," *South. M. J.* 58:1255-1256 (Oct)65

Most patients who are troubled enough about some physical defect to seek out a plastic surgeon, even though this defect is a relatively minor one, deserve serious consideration as candidates for surgery.

These so-called minor physical defects are usually of the nose, facial skin, breasts or ears. They often appear as insignificant to the outside world, yet their correction usually returns large rewards in terms of restored self-confidence, increased happiness and more remunerative employment.

There are a few instances in which the patient is using his defect as an excuse for some failure in life and in these situations the excuse should probably not be removed as long as the need for it persists. In most instances,

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### IN CEREBROVASCULAR INSUFFICIENCY

leading to such symptoms as  
mental confusion, diplopia,  
vertigo and lightheadedness.



### IN PERIPHERAL VASCULAR DISEASE

where ischemia causes  
pain, spasm, ache,  
intermittent claudication; a  
coldness, numbness or ulcer  
of extremities.



however, surgery is justified if it simply appears "likely," as Blair put it, that the patient's hopes can be realized.

What we think we look like to the outside world seems to be far more important as a measure of our self-esteem than what we actually do look like.

**Foster, Richard S., M.D., Wade H. Shuford, M.D., and Stephen Weens, M.D., 80 Butler Street, S.E., Atlanta, Georgia 30303, "Selective Renal Arteriography in Medical Diseases of the Kidney," Am. J. Roentgenol. 95:291-308(Oct)65**

During the past three years percutaneous selective catheterization of the renal arteries followed by injection of radiopaque contrast material has been utilized to study the radiologic features of the renal arterial vasculature in the so-called medical diseases of the kidney. These studies have revealed that there are distinguishable lesions of the small renal arteries present on the selective arteriogram which are not generally recognized by abdominal aortography, and that these lesions fit certain patterns which may be helpful in differentiating primary vascular from parenchymal diseases of the kidney.

The arteriographic features of benign and malignant hypertensive vascular disease, segmental arterial occlusion, pyelonephritis, hydronephrosis, tuberculosis, polycystic renal disease, and unilateral vein thrombosis are described.

**Hayes, Wayland, Jr., M.D., Ph.D.; and Pirkle, Carl I., M.D., CDC, U.S. Public Health Service, Atlanta, Ga., "Mortality From Pes-**

**ticides in 1961," Environmental Health 12:43-55(January)1966.**

There were 119 deaths in 1961 possibly related to pesticides, and 111 of them were ascribed to identifiable materials. About 90% of deaths attributed to pesticides were correctly diagnosed as indicated by evidence of adequate exposure, a consistent clinical course, or appropriate laboratory and autopsy findings. Of the 111 reasonably definite cases, 51% were in children under ten years old; at least 58% involved compounds older than DDT; not more than 15% were occupational; and several cases were associated with alcoholic intoxication, mental deficiency, improper storage of the poison, or some other special circumstance. Safer use of pesticides in this country should be attainable because, especially in children, a few countries already have a lower mortality rate associated with these useful materials.

**Kite, Hiram, Jr., M.D., 490 Peachtree St., N.E., Atlanta, Ga. 30308, "Morton's Toe Neuroma," Southern Medical Journal 59:20-25(January)1966.**

Morton's toe neuroma is a painful condition of the foot occurring chiefly in women between the ages of 30 and 50 years. The pain comes on in attacks, is very severe, and usually begins between the third and fourth toes. It is described as sharp, sticking, burning, and is so severe the shoe must be removed in an effort to ease the pain. The patient can be completely relieved of the pain by the removal of the

tumor under local anesthesia. This operation has been performed on 101 women and four men. The neuroma was found between the second and third toes in 11% of the patients, and between the third and fourth toes in 89%. Ten of the women developed pain in the opposite foot at a later date, and had a neuroma removed from this foot. All were completely relieved of pain.

**Turner, John S., Jr., M.D.; Staats, Ethan, M.D.; Stone, H. Harlan, M.D., and Logan, Robert, M.D., Division of Otolaryngology, Dept. of Surgery, Emory Univ. School of Medicine, Atlanta, Ga., "Use of Gentamicin in Preparing the Chronically Infected Ear for Tympanoplastic Surgery," Southern Medical Journal 59:94-97(January)1966.**

Careful cleansing of the middle ear combined with displacement of an antibiotic solution into the mastoid air cells using a pneumatic otoscope has been found to be an effective regimen for promptly preparing the chronically infected ear for tympanoplastic surgery.

Bacteria recovered from 68 consecutive patients with otorrhea and tympanic perforation showed 100% sensitivity to the antibiotic used in this study. Recalcitrant *Pseudomonas* infections particularly have been responsive to the mechanical and chemical methods employed.

A new broad-spectrum antibiotic, gentamicin, was used as a 0.3% topical solution with complete patient acceptance and without any evidence of cochlear or vestibular toxicity.



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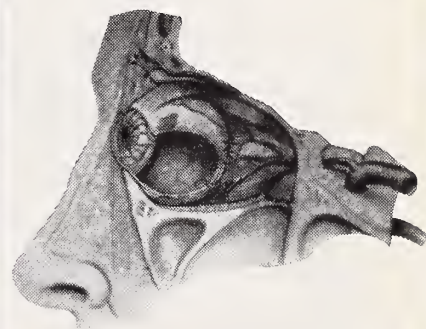
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in which vasospasm and impaired circulation are factors.

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# THE ASSOCIATION



## DEATHS

**J. H. Hodges, Sr.** of Hapeville died January 31, 1966. He is survived by a son, James H. Hodges, Jr., Hapeville; three daughters, Mrs. D. W. O'Quinn, Miami, Fla.; Mrs. J. H. Summerour, Winder; Mrs. C. G. Burt, Atlanta; and a sister, Miss Susie Mae Hodges, Sandersville.

**Roy Samuel Leadingham**, a former faculty member of the Emory University Medical School and medical missionary of the Presbyterian church died February 3, 1966, at Milwaukee, Wisconsin. Dr. Leadingham moved from Atlanta to Milwaukee in 1964.

He had served on the Emory faculty from 1921 to 1964 as an Assistant Professor and later Associate Professor. He also had a private practice in Atlanta and was an elder in the Central Presbyterian Church.

A native of Iowa, he served as a medical missionary to Korea from 1912 to 1919 when poor health forced him to return to the United States. He served for a time as chief of the Veterans Hospital in Murfreesboro, Tennessee.

Dr. Leadingham had published a number of scientific articles in medical publications and was a member of several professional organizations.

Survivors include his wife and a son, Harry P. Leadingham, former Associated Press writer in Atlanta and former bureau chief in New Orleans and Milwaukee.

**Joseph Righton Robertson**, 84, of Augusta died February 5, 1966, after an extended illness.

Dr. Robertson graduated from the University of Maryland Medical College and returned to Augusta where he was engaged in the practice of urology for more than 50 years.

For a number of years he was Associate Professor of urology at the Medical College of Georgia and was Emeritus Professor of clinical urology at the time of his death.

Dr. Robertson was a fellow of the American College of Surgeons, Past President of the Georgia Urological Society and the Richmond County Medical Society, member of the American Urological Association and the American Medical Association, former chairman of the Richmond County Board of Health and former member of the Richmond County Board of Education.

During World War I, he was commissioned captain in the Medical Corps, U. S. Army, and served as urologist of the 26th and 82nd divisions.

Dr. Robertson was a member of the Episcopal Church of the Good Shepherd where he served on its vestry for many years. He also was a member of the Louis L. Battie Post, American Legion.

Survivors include his widow, Mrs. Catherine Heard Robertson; two sons, Heard Robertson, Augusta, and J. Righton Robertson, Jr., College Park, Md.; six grandchildren; and several nieces and nephews.

## COUNTY MEDICAL SOCIETIES

Frank Stelling, M.D. of Greenville, South Carolina, was the guest speaker for the February meeting of the **Bibb County Medical Society**. Dr. Stelling, one of the nation's outstanding orthopedists, discussed "Congenital Anomalies," illustrated with color slides.

At the February 21 meeting of the **DeKalb County Medical Society** guest speaker for the evening was Ed Dorney, M.D., Atlanta, who spoke on "Bedside Diagnosis of Arrhythmia."

**Washington County Medical Society** has been one of the sponsors for four public forums on stroke rehabilitation held recently in Sandersville. Thomas W. Brooks, III, M.D., is Chairman of the Stroke Forums Committee, Washington County Unit, Georgia Heart Association. The forum is an educational program designed to help the 40,000 victims of stroke in Georgia.

## PERSONALS

The American College of Radiology elected four new Georgia fellows at their meeting in Chicago, February 1-5, 1966. They are **Neal F. Yeomans, M.D.**, Waycross; **George W. Brown, M.D.**, Griffin; and **Joseph L. Izenstark, M.D.** and **Edward S. Bivens, M.D.**, Atlanta. At the same meeting **J. Frank Walker, M.D.**, Atlanta, was elected to the Executive Committee of the Board of Chancellors of the American College of Radiology.

Five Georgia physicians will be installed as fellows of the American College of Obstetricians and Gynecologists at its Annual Meeting May 2-5, 1966, in Chicago. They are **Dan B. Kahle**, Atlanta; **Peter Hydrick**, East point; **Elton L. Copelan**, Toccoa; **Henry D. Scoggins**, Augusta; and **James H. Jenkins**, Rome.

### First District

**James H. Gordon**, Lyons, District Medical Director for several area counties, retired from medical practice on March 1, 1966.

### Third District

**Jane Rivers**, Columbus, was recently the subject of a feature article in the *Columbus Ledger*, citing her work as the Director of the Child Development and Evaluation Center at the Muscogee County Health Department. Dr. Rivers is the mother of six children.

### Fourth District

**William B. Fackler, Jr.**, LaGrange, spoke on "Heart Disease, Diet and Blood Vessel Disorders" February 1, 1966, at the Jewish Educational Alliance in Savannah. A panel of Savannah doctors took part in the discussion that followed Dr. Fackler's presentation. The panel



members were **Mason G. Robertson**, **Zellner C. Young**, **F. Debele Maner**, and **Lamont E. Danzig**.

#### Fifth District

Atlanta surgeon, **Charles R. Hatcher, Jr.**, Assistant Professor of Thoracic Surgery at Emory University School of Medicine, won top honors in the Gold Medal Forum at the March meeting of the 34th Annual Southeastern Surgical Conference held in Atlanta. Dr. Hatcher's winning paper dealt with using heart pacemakers as protective as well as preventive devices; experiments were done with dogs. **Nicholas Exarhos**, Senior Resident in Thoracic Surgery at Emory worked with Dr. Hatcher on the experiment.

At the 28th annual meeting of The South Atlantic Association of Obstetricians and Gynecologists meeting at the Americana in Bal Harbour, Florida, **William H. Grimes**, of Atlanta, was elected President-elect.

**Lester Rumble, Jr.**, Atlanta, attended the Congress on Medical Education in Chicago, February 3-7, 1966.

On February 8, Dr. Rumble was a guest speaker at the Postgraduate Clinical Symposia of the University of Kansas School of Medicine. The subject of his presentation was "The Role of Inhalation Therapy in the Treatment of Chronic Obstructive Lung Disease."

Alpha Epsilon Delta, the international premedical honor society held its 16th National Convention at Emory University, Atlanta, April 14-16, 1966. Presenting talks at the meeting were **Harry Williams**, Atlanta, and **Walter Rice**, Dean of the Medical College of Georgia, Augusta.

**A. H. Letton** of Atlanta was recently reelected Secretary-Director of the Southeastern Surgical Conference for 1966.

**Cheney C. Sigman, Jr.**, Atlanta, attended the postgraduate course and the annual meeting of the American Academy of Allergy in February, in New York City. He exhibited, on behalf of the Pollen and Mold Committee the results of Aeroallergen Surveys in Atlanta for the years 1964 and 1965.

**William A. Hopkins**, Atlanta, Chief of Thoracic Surgery at St. Joseph's Infirmary, spoke in February to the Canton Rotary Club. Dr. Hopkins was speaking in connection with the Georgia Heart Association and told the Rotary members of the many recent advances that have been made in heart surgery and disease treatment in the southeastern section of the country.

**J. C. Tanner** of Atlanta spoke to the Southwest Georgia Medical Society in January on his original method of meshed skin grafting, presenting illustrated material in colored films and slides.

The 1966 Calhoun Heart Fund Campaign opened in January with **Haywood N. Hill** of Atlanta as the guest speaker.

**Walter C. Earle**, Atlanta, was recently installed as the new President of the Atlanta Association for Retarded Children. New Vice-President is **Thomas L. Tidmore, Jr.**, also of Atlanta.

Two Atlanta physicians, **Joseph Patterson** and **Corbett Turner** were guest speakers at a recent conference on "The Battered Child" held at the Georgia Mental

Health Institute. Dr. Patterson discussed the "Battered Child Syndrome," from a medical standpoint and Dr. Turner described the psychiatric aspects of the problem. The conference was sponsored by the Maternity and Child Health Council and the Mental Health and Psychiatric Nursing Council of the Georgia State League for Nursing in cooperation with the Georgia Association for Mental Health.

**Dr. and Mrs. Joseph Izenstark** attended Mardi Gras in New Orleans, La., as guests of Dr. Jorgen Schlegel, Professor of Surgery at Tulane University, and Mrs. Schlegel. Mrs. Izenstark, the 1962 Queen of the Krewe of Alpheus, was presented at the 20th Century Ball of the Krewe. Her husband is an active member of the group.

Dr. and Mrs. Schlegel entertained at a black tie reception for the Atlantans, who also attended other Mardi Gras functions.

The Forest Park Kiwanis Club had as its guest speaker in January **Elbert P. Tuttle, Jr.**, Atlanta, who presented an informative talk on the progress made in the field of medical research. Dr. Tuttle's research concerns the cardiovascular field.

#### Sixth District

**B. W. Forester**, Macon, has been reappointed to the State Board of Health for a six-year term.

A new program to help deaf patients at Milledgeville State Hospital has begun under the direction of **William L. Barton**, Macon. The program includes the stapedectomy operation which restores hearing to about 90% of the persons who have the operation. Dr. Barton has been the attending consultant at Milledgeville State Hospital in ear, eye, nose and throat for 15 years.

**Waldo E. Floyd**, Macon, was recently made a fellow of the American College of Surgeons in Atlantic City, N. J.

#### Seventh District

**Davis S. Reese**, Carrollton physician, was named Carrollton's Man of the Year for 1965 during the annual meeting of the Carrollton Chamber of Commerce January 21, 1966, at West Georgia College.

**Donald Thomas** of Dalton was recently named Dalton's Outstanding Young Man of the Year in the annual awards program of the Junior Chamber of Commerce.

**Luke G. Garrett, Jr.**, former Mayor of Austell, was one of five Cobb citizens to receive a "Public Service Award" at the annual dinner meeting of the Cobb County Chamber of Commerce in Marietta, January 21, 1966. Dr. Garrett received a plaque in recognition of his public service to his community.

#### Eighth District

**William A. Dickson** received a certificate of appreciation from the Nashville Rotary Club in February for services rendered to his club and community. Dr. Dickson has moved from Nashville to Hahira where he has set up medical practice.

**Vilda Shuman**, Waycross, President of Pilot International, presided over the training session held at the Kellogg Center of Michigan State University, East Lansing, Michigan, at Pilot International's Fifth Highway Traffic Conference.



## THE ASSOCIATION / Continued

**Yancey Franklin Carter, Jr.** of Nashville has been appointed to succeed himself as a member of the State Board of Medical Examiners. Dr. Carter is a past president of the Examining Board.

### Ninth District

**Henry S. Jennings, Jr.** of Gainesville spoke to the students at Dawsonville High School, February 11, 1966. Dr. Jennings spoke under the sponsorship of the Georgia Heart Association and his topic was smoking. The public was invited.

Winder physician, **George R. Parkerson**, spoke to the members of the Winder Elks Auxiliary at their regular dinner meeting, February 3, 1966. Dr. Parkerson's talk concerned the heart.

**T. L. Hodges**, Clarkesville, attended the January Symposium on Problems on Reproductivity and Infant Care which was presented in Toccoa. Members of the faculty of the Medical College of Georgia, Augusta, were featured members of the program.

**C. L. Ayers**, a veteran Toccoa physician, was honored recently by friends and relatives on his 89th birthday anniversary. Dr. Ayers, a native of Carnesville, is a former member of the Georgia legislature.

**William T. Langston**, a native of Lexington, Kentucky, has joined **Harvey M. Newman**, Gainesville, in the practice of pediatrics.

**Jesse Carlton Dover** of Clayton, 91-year-old general practitioner in Rabun County since 1900, retired in February from the Rabun County School Board after serving in that capacity for 60 years.

### Tenth District

**Richard S. Owings** of Augusta, was guest speaker at the February meeting of the Richmond County Medical Assistants Association. Dr. Owings' topic concerned the establishment of a clinic for children in the Southeast. Dr. Owings is a pediatric surgeon.

**Frederick P. Zuspan** of Augusta has been named Joseph Bolivar De Lee Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Chicago.

He also will be Chief of Service of the Chicago Lying-in Hospital, which is part of the University's hospitals and clinics.

In these positions, Dr. Zuspan will succeed Dr. M. Edward Davis, who will become the Joseph Bolivar De Lee Professor Emeritus of Obstetrics and Gynecology.

The appointment, effective April 1, 1966, was announced by Edward H. Levi, Provost of the University.

Dr. Zuspan was chairman of the Department of Obstetrics and Gynecology at the Medical College of Georgia.

## 1966 CALENDAR OF MEETINGS

### State

Postgraduate Courses sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta. Through May 12.

May 3-4—Trauma, Including Disaster Medicine, sponsored by Medical Education for National Defense, Medical College of Georgia, Augusta.

May 5-7—Ninth Biennial Cardiovascular Seminar, "Newer Methods in Ischemic Heart Disease," presented by the Section of Cardiology, University of Miami School of Medicine and the Heart Association of Greater Miami, Carillon Hotel, Miami Beach, Fla.

May 7-8—Techniques in Pulmonary Therapy, presented by the Medical College of Georgia, Martinique Motel, Columbus.

May 8-10—112th Annual Session of the Medical Association of Georgia, Columbus, Ga.

May 16-19—Third Atlanta Postgraduate Course in the "Treatment of Trauma and Children's Orthopedic Surgery" sponsored by the Committee on Injuries of the American Academy of Orthopedic Surgeons, Riviera Motel, Atlanta.

May 18-20—A Postgraduate Course, "Modern Physical Diagnosis of the Cardiovascular System," presented by the Department of Medicine, Emory University School of Medicine, Grady Hospital Auditorium, Atlanta.

May 19-21—Symposium on Psychiatry and Neurology: A Practical Approach, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla.

July 15-16—Twentieth Annual Rocky Mountain Cancer Conference, Brown Palace Hotel, Denver, Colo.

### Regional

May 7-8—Anesthesiology Residents' Conference (Regional Meeting), University of Virginia, Charlottesville, Va.

June 30-July 2—Symposium on Clinical Aspects of Renal Disease-Ischemic Heart Disease and Cardiac Diagnosis (Sponsored by Tidewater Heart Association, Council on Clinical Cardiology, American Heart Association), Cavalier Hotel, Virginia Beach, Va.

### National

May 1-5—International College of Surgeons (U.S. Section) (E) Shamrock-Hilton, Houston.

May 23-25—Annual Meeting of the American Thoracic Society, Medical Section of the National Tuberculosis Association, San Francisco, Calif.

May 30-June 1—American Ophthalmological Society (M), The Greenbrier, White Sulphur Springs, West Va.

June 2-4—American Gynecological Society, The Homestead, Hot Springs, Va.

June 26-30—American Medical Association Annual Convention, Chicago.



## AND EXECUTIVE COMMITTEE ACTIONS SUMMARY OF RECENT MAG COUNCIL

(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal).

### Executive Committee of Council Telephone Conference/January 31, 1966

#### Appointments—

(a) *Cardiovascular Disease*—President Alexander stated that MAG had been asked to appoint three members to the "Follow-Up Committee" for the Second National Conference on Cardiovascular Diseases. As Dr. T. L. Ross, Macon; J. W. Chambers, LaGrange; and Henry S. Jennings, Gainesville, had previously been appointed as MAG representatives to this committee, the Executive Committee voted to re-appoint them.

(b) *State Board of Health*—The MAG was asked by the Governor's office to nominate 6th and 8th District representatives to the State Board of Health as the present two members' terms were expiring in July, 1966. Dr. Alexander agreed to bring the matter before the 6th District meeting on February 9 and the 8th District has submitted the following nominations: R. E. Perry, Brunswick; W. A. Dickson, Nashville; and Van B. Bennett, Valdosta. Dr. Alexander was asked to inform Mr. Henry Neal in the Governor's office that the nominations would be submitted after February 9.

*Report of "Heart, Stroke and Cancer" Meetings*—Dr. Alexander reported on a January 12 meeting of the MAG Board of Medical Education, at which time it was recommended that a meeting of groups interested in the government health programs including the Heart, Cancer and Stroke Amendments (P.L. 89-239) be held on January 23 at the Marriott Motor Hotel, Atlanta. The purpose of this January 23 meeting would be to gain further information from Mr. Karl Yorty, of the National Institutes of Health. Representatives of the State Department of Public Health, the Hospital Association, Nurses Association, Dental Association, Vocational Rehabilitation, Communicable Disease Center, Georgia Heart Association, Georgia Division, American Cancer Society, and other voluntary health agencies, would be invited to this meeting, and it would be co-sponsored by the Medical College of Georgia, Emory University School of Medicine, and MAG.

Dr. Alexander then reported that the January 23 meeting at the Marriott was well attended by representatives of the above organizations, as well as several members of the MAG Medical Education Board, and himself. It was explained that project planning grants were available to qualified applicants. It was agreed that the medical schools should apply for a planning grant for continuing medical education and that representatives should meet in the very near future to proceed with the application for the grant. The Executive Committee agreed that Dr. Thomas W. Goodwin, Chairman of the MAG Medical Education Board, should represent the Association, with Dr. T. A. Sappington, Thomaston, Vice Chairman of the Board, acting as alternate. Dr. Alexander asked that Dr. Arthur Richardson be notified of this action, as well as Drs. Goodwin and Sappington.

### Executive Committee of Council/February 5, 1966

*Liaison With State Board of Health*—Dr. Alexander reported on his attendance at the last State Board of Health meeting and stated that the Board was desirous of publishing information in the *JMAG*, perhaps on a monthly basis. He had asked the Board to make such a request to the Editor of *JMAG*. President-Elect Walter E. Brown was asked to attend the next meeting of the Board at State Department of Health Building, Atlanta, February 17-18.

*Councilor Redistricting*—Mr. Krueger stated that in order to implement the instructions from Council on Councilor Redistricting, he would like to mail a letter to all of the districts, counties and county medical societies asking for nominations. He then reviewed the proposed letter which the Executive Committee approved.

*Project "Head Start"*—Mr. Krueger reported that he has received a call from Dougherty County Medical Society regarding the position of MAG on "Project Head Start." On motion (Mauldin-Brown) it was voted to inform the society that the Association is interested in the project and will help with the distribution of information but the final jurisdiction of each local project should be the responsibility of the county medical society.

*NEW BUSINESS*—Mr. Krueger discussed the following items:

(a) *AMA Congress on Environmental Health*: After discussion, on motion (Brown-Mauldin) it was voted not to send a representative to this meeting. The meeting dates are April 4-5, 1966, Chicago.

(b) *AMA Legal Conference*: It was voted to send the Secretary or his designated alternate, and the MAG Attorney is to be asked if he wishes to attend at his own expense. The conference is scheduled for April 15-16, 1966, Chicago.

(c) *MSEA Seminar*: The Executive Committee voted to send Mrs. Catherine Wooten to the seminar, August 22-24, 1966, Chicago, with expenses to be paid from Office Travel.

*HEADQUARTERS OFFICE REPORT*—Mr. Krueger reported on the following:

(a) Mr. Donald Taylor, Executive Vice President of the Iowa Medical Society, will visit the MAG Headquarters on February 9-10.

(b) The MAG County Society Leadership Conference, February 5-6, program was reviewed.

(c) The Title 19 meeting held by AMA, January 20-21, in Chicago, was discussed.

*Paramedical Training Program*—Dr. John T. Godwin, Atlanta, reported that the DeKalb Technical School would like to establish a course for the training of Certified Laboratory Assistants and that it was his recommendation that if certain standards were established as prescribed by the American Society of Clinical Pathologists and approved by the AMA, such a course would be of great benefit.

After discussion, on motion (Mauldin-Eldridge) it was voted to recommend to Council that the school be approved on the basis of the following recommendations:

(1) that the school have an advisory committee of pathologists;

(2) that all prospective students be interviewed and approved by a pathologist before acceptance;

(3) that the program be reviewed annually by the advisory committee; and

(4) that the course of study be 18 consecutive months.

*Paramedical Recruitment Program*—Dr. Godwin also reported that the Georgia Hospital Association has set aside funds for a paramedical recruitment program with the funds to be allotted for travel over the state to recruit this type of personnel. Dr. Godwin recommended that MAG take immediate action to establish a statewide paramedical recruitment program, and after some discussion it was voted to refer this matter to Council. Dr. Godwin was asked to attend the March Council meeting to present this item.

*Military "Medicare" Contract*—Dr. Mauldin reported, in the absence of Dr. Jennings, on the Military "Medicare" Contract status. A meeting was held with the contracting officer of ODMC on January 19 and the "Fee Negotiating" Committee members. The final decision was that MAG would send procedures and fees to ODMC for their suggestions and another meeting would be held for final negotiation. As this information cannot be sent to ODMC immediately, Dr. Mauldin recommended that a letter be written to ODMC asking for a 90-day extension until Council can approve the contract, after the procedures and fees have been agreed upon by ODMC and MAG. This was approved.

*Hospital Standards Meeting*—Dr. Mauldin reported on the meeting with the State Department of Public Health regarding hospital standards under P.L. 89-97.

*State Family and Children Services Department Drug Program and Advisory Committee*—Dr. Alexander stated that Mrs. Schaefer had asked that an advisory committee be appointed to work on the drug program, to be composed of two MAG members, two Georgia Pharmaceutical Association members, one Emory Medical School representative and one Georgia School of Pharmacy representative, as well as Dr. Mauldin and Mr. James Segars. On motion (McDaniel-Brown) it was voted to have representation on the committee with the President, to serve as one MAG representative and appoint another member, or to appoint two representatives if he cannot serve.

#### OLD BUSINESS—

(a) *Georgia Society for Crippled Children and Adults Request for Grant*: Dr. Alexander reported that the letter of



## SUMMARY OF MINUTES / Continued

endorsement of a Health Services Project Grant for the Georgia Society for Crippled Children and Adults requested, had been written.

(b) *Medical Education and Research Buildings, Augusta:* The Executive Committee was informed that the building had been named and that Richmond County Medical Society had been so notified, per the action of the December Council meeting.

**NEW BUSINESS**—(Items under New Business were continued from those Mr. Krueger discussed previously).

(e) *MAG Attorney:* The possibility of a conference with the MAG attorney regarding the retainer fee was discussed.

(f) *Date and Site of March Executive Committee Meet-*

*ing:* By general agreement it was voted to hold the March meeting, March 12, 10:00 a.m., Buccaneer Motor Lodge, Jekyll Island.

(g) *MAG Pension Plan:* Dr. McDaniel stated that the government had ruled that the Association could not wait until March each year to determine the amount of money to be contributed to the pension plan, and therefore, the Association would have to set aside so much money each year for this purpose. It was then voted to ask the MAG attorney to work up a plan for report at the March Council meeting.

*Georgia Youth Council*—Dr. Alexander reported that the Georgia Youth Council had asked for advice concerning the sponsorship of an educational program on venereal disease in the public schools. He was asked to appoint a committee to work with the Youth Council and the Executive Committee, by general agreement, voted to ask Dr. Alexander to appoint this committee.

## GEORGIA WINS FELLOWSHIP FOR FOREIGN MEDICAL STUDIES

Thomas E. Dill, a junior in the Medical College of Georgia, Augusta, has been awarded a \$662 fellowship which will enable him to broaden his clinical training by assisting, for 11 weeks this summer, at a small mission hospital serving eastern Ecuador.

Dill is one of 35 American medical students who have been awarded Smith Kline & French Laboratories Foreign Fellowships by the Association of American Medical Colleges.

Dill, the first student from his school to receive a Smith Kline & French Foreign Fellowship, will work in a hospital in Shell Mera, Ecuador, a town of about 400 population. He also will make occasional trips to isolated mission stations. Shell Mera Hospital has 28 beds

and is equipped for major surgery, obstetrics, x-ray and blood transfusion services. One missionary doctor and one Ecuadorian doctor are stationed there as well as six registered nurses. The hospital serves all of eastern Ecuador, which has a population of 65,000.

Now entering its seventh year, the Smith Kline & French Foreign Fellowship program was established to provide an opportunity for American medical students to widen their medical horizons in cultures very different from their own.

In the past six years 180 Fellows from 74 medical schools have served in hospitals and clinics in 45 countries of Africa, Asia and Latin America.



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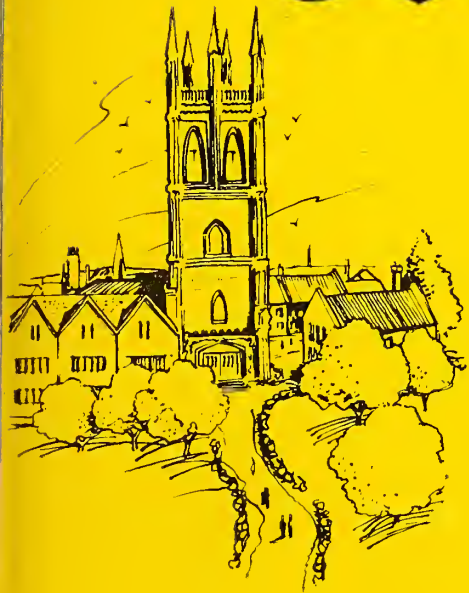
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## AT THE CROSSROADS

Walter E. Brown, M.D., *Savannah*  
President, Medical Association of Georgia



IT IS WITH a deep feeling of humility that I stand here before you today, knowing full well that there are here today many far more able and far more qualified to be in this position than myself. However, I will yield to none in making every effort, and exercise all care and consideration in doing my part to further the interests of the Medical Association of Georgia and medicine in Georgia at all levels. So, as in humility, I come also in pride that you have seen fit to name me as your president.

After many years in our local society, the Georgia Medical Society, in committee assignments and in council, it has become and is evident that our association is full grown in members, in influence and in the scope of its activities.

### Encompassing Activities

These activities now encompass professional, social, legal, religious, charitable and humanitarian aspects of our society, and it will be our aim to continue to aid and cooperate with all these facets of our community life where compatible with our aim and efforts and not contrary to our teachings and beliefs.

It is more and more evident that the operation and success of MAG is now no longer a small endeavor.

No one realizes more than I how much we are now dependent upon the active, efficient and willing cooperation of many MAG committees (who give freely of their valuable time) to further the advancement of medicine and medical care to all in Georgia.

This is in full manner also true of Council, the Executive Committee, the House of Delegates and in extra manner the efficient and ever helpful headquarters office staff, without whose help and guidance we could not function. I also realize how difficult it will be for me to follow in the footsteps of the efficient and hardworking George Alexander who is retiring as our president. He has done an excellent

job and deserves the gratitude of all the members of the Medical Association of Georgia.

We are at a crossroads today facing an entirely new concept and view to the future in the practice of medicine in this country which is totally foreign to our teaching, to our thinking and to how we will be called upon to conduct our practice and indeed in some areas as to how we shall conduct ourselves as physicians.

It is not necessary at this time to review in detail the provisions and ramifications of the Medicare law. This has been adequately covered in repeated meetings and special called meetings of AMA and its appropriate committees. All this is well covered in our journals and allied publications.

Suffice it to say that as one or all groups we cannot collectively refuse to abide by the law. However, as in the past, we as individual physicians may still choose and select those whom we desire to treat, and we cannot be forced to care for anyone against our will. In this way we can continue to maintain our close physician-patient relationship as we do now, and by our present method and such relationship offer the best medical care in the world.

### To Abide by the Law

We in MAG will abide by the law, but we will use all ethical and legal means at our disposal to prevent further encroachment of the Federal Government by law and regulation upon our profession and how we practice in the future. We have been told that the present law is only a beginning and that the aim of the Government is to rapidly expand the law to cover more and more of our population, so that I can foresee the total control of medical practice by Federal regulation.

At this point we urge for this reason that all of us make every effort to support and to contribute to GaMPAC and AMPAC, who are constantly on the alert and lookout for new and unfavorable legis-



lation involving our profession, and to resist passage of such legislation by actively contacting our legislators, congressman and senators when requested to do so by MAG, AMA and our legislative committee. Likewise, it is important to support favorable legislation and actively support candidates favorable to our views and aims. These should include members of our profession.

### Productive Meetings

During the past year we have had productive and fruitful meetings with the State Board of Health, involving areas of mutual interest. At present a member of our Executive Committee meets with the Board monthly and a member of the Board attends our Council meetings. We shall continue to offer assistance and cooperation with the Health Department and other state agencies working for continued improvement and expansion of activities in the areas of mental health programs in Georgia.

Also, we must continue to assist in furthering the general health and welfare of our people. Administration of Medicare will be by the Health Department (John Hancock agent for title XVIII).

We are greatly concerned with the increasing and frightful toll of highway deaths in our country (49,000 dead and 1.8 million partially or totally disabled in 1965, 1,350 dead in Georgia, 19,000 injured, 35 million monetary losses). I feel that we should cooperate with the Department of Public Safety and State Government in formulating and working for passage of more stringent traffic regulations and more safety features on new cars. Also, stricter requirements are needed for driving licenses and stiff penalties enforced for anyone convicted of drunken driving or repeated breaking of traffic laws. This has now become of medical importance.

### Of Real Importance

We are becoming a very heavily industrialized state and soon the problem of air and water pollution will become of real importance. We should cooperate in the study of this problem as it arises and offer assistance to the State Health Department (State and Local), to civic organizations and to industry when such problems properly address themselves to us and fall within the scope of our activity.

With the advent of increased demand on our hospital facilities which will inevitably follow the activation of Medicare and increased welfare care of the aged and dependent, we will surely find ourselves short in all areas of paramedical care and personnel to staff present and expanding hospitals, nursing and convalescent homes, and indeed our

own offices and clinics. We should foster and encourage present programs and aid in setting up of new ones to train the number of persons who will be needed in the future. These will and should include training of nurses, nurses aides, laboratory technicians, x-ray technicians, office assistants, medical stenographers, etc.

### To Increase Graduates

In like manner we shall very rapidly fall even further short in the matter of educating new physicians. Even now there is an active program to increase the number of medical schools in this country as well as to enlarge present facilities so as to increase the number of graduates each year. We should be ever ready to assist and advise with our two great medical schools and to cooperate with them in whatever areas we can to implement such plans as they may now have or contemplate activating to increase the output of physicians in our state.

Emory University Medical School and the Medical College of Georgia are great assets and adjuncts to organized medicine in Georgia. They constantly work to keep abreast and ahead in instruction, to turn out well-trained graduates, research programs and frequent short seminars and courses to aid us in keeping up to date with advances and newest changes in concepts of medical education and progress in all fields. They are always ready and anxious to provide speakers for our various county, district, state and specialty organizations and auxiliary organizations.

We are greatly concerned about the diminishing attendance at the annual meetings. Preparation for these is practically a year-long effort, beginning soon after the conclusion of each session. Dr. Spitzer, chairman, and the annual sessions committee, the specialty groups and the many host society committees and headquarters staff work diligently and long to organize and activate each meeting.

### Importance of Attendance

Much work and thought is given to preparing an interesting and revealing program, both scientific and social. Highly qualified speakers from all sections of the country are obtained for all specialty and general sessions and we should attend as many of these as possible. It is a source of concern for prominent guest speakers to appear before a very small number of our members. We have abbreviated the meetings, so as to cause a minimum loss of time from our practice and time away from home. We urge all members to make an extra effort not only to attend, but to take part in, and contribute to the success of each session. It is, after all, your organization and its growth and continued success and influ-



ence is dependent upon active participation of all members in all of its activities. Here we renew old acquaintances and make new friendships which last for many years.

We have another vital problem facing us, not only in Georgia but nationwide. This is the growing problem of alcoholism. The number of alcoholics and chronic drinkers is ever increasing and this should address itself to all of us. First, for the impact it has on the health of the individual, secondly its effect on economics and moral aspect of those involved, loss of income, broken families, loss of earning capacity, loss of self-respect, moral degeneration, etc.

### Active Rehabilitation

We have now an active program of rehabilitation and aid to the alcoholic, a state hospital in Atlanta, and in several areas alcoholic clinics are doing excellent work. We should be ready to aid in every way available to us those who are working in this area and cooperate in making more help available to those in need. Alcoholics Anonymous also is doing a fine job in aiding and encouraging those harassed and burdened by this problem.

Our State Vocational Rehabilitation program is a joint state and federal project. Primary aim is to correct or reduce and treat physically handicapped and to train permanently handicapped (blind, deaf, etc.) so that they may be gainfully employed or re-employed, thereby reducing the number of persons dependent on government or social agencies for maintenance and support. The Georgia program is outstanding. It has ranked in the top three states in the nation for the past 20 years. Last year 7,221

cases were rehabilitated, most of whom are now totally or partially self-supporting. These represent cases from more than 30 categories of handicaps.

Vocational Rehabilitation and Department of Family and Children's Services now have research and demonstration projects to investigate and rehabilitate alleged disabilities of many on aid and to families of dependent children. Two of 27 such projects in the nation are now in Georgia (Atlanta and Savannah). I feel that the Vocational Rehabilitation program has made and is making great strides in health improvement and in adjustment of handicapped persons, and that we should offer help and cooperation in its continued activity and expansion.

### An Uncharted Course

We approach an uncharted and uncertain course in the future practice of our profession. Many of the requirements already existing and to be formulated will be foreign to our precepts, concepts and methods of established medical procedures and principles which we have so faithfully followed. Believing as we do, that our present system of medical care and practice is by far the best for the welfare of our patients, we will find it difficult to subscribe to and adjust to many radical changes which are certainly facing us. We shall endeavor to constantly bear in mind that our total thoughts and efforts shall continue to be directed at offering at all times the highest quality of medical care to those in need, and that nothing regulatory or directive shall divert or deter us from this purpose and determination.

May we seek and invoke divine guidance and direction for all of us in the fulfillment of our aims and efforts.

*1020 Drayton Street*

## EMORY GYN-OB DEPARTMENT TO SPONSOR SPRING POSTGRADUATE CONFERENCE

The Department of Gynecology-Obstetrics, Emory University School of Medicine, will sponsor on May 26 and 27, 1966, a Postgraduate Conference entitled, "Family Planning and Family Life Education." The Conference, designed for Physicians, Nurses, Educators, and Public Health Workers, will feature a most outstanding guest faculty. Participants will include Dr. Mary Calderone, Executive Director of the Sex Information and Education Council of the United States; Dr. Eugene Linton, Department of Obstetrics-Gynecology, Bowman Gray School of Medicine; Dr. Jack Whitridge, Maryland State Health Department, Baltimore, Maryland; and Dr. Johan Eliot, School of Public Health, University of Michigan. Other guest faculty will include Mrs. Ferne Jackson, Muscogee County (Ga.)

Health Department; Dr. Helen Bellhouse, Georgia State Health Department; Miss Hannah Mitchell, Georgia State Health Department; Dr. Charles Butler of the Department of Psychiatry, Emory University School of Medicine; and Mr. Russell Richardson of Planned Parenthood-World Population.

The Conference will convene on May 26 at 12:00 noon in the Main Auditorium of Grady Memorial Hospital. Adjournment will be on Friday the 27th at 3:45 p.m.

Persons interested in additional information are invited to write Gyn-Ob Postgraduate Education, 69 Butler Street, S.E., Atlanta, Georgia 30303. There will be no registration fee for those desiring to attend; however, advance registration is requested.



# CHRONIC DIARRHEA IN INFANCY WITH RESULTANT DISACCHARIDE MALABSORPTION

Eugene C. Jarrett, M.D.

Gerald H. Holman, M.D., *Augusta*

- The disaccharide splitting enzymes are localized in the brush border portion of the lining cells of the small bowel.

THE MANAGEMENT of an infant or child with chronic diarrhea continues to be an extremely difficult problem. During the last few years studies have shown that in many of these children the difficulty in management is due to the deficiency or lack of intestinal disaccharidase enzyme activity, either as the primary cause of the diarrhea or secondary to the chronic diarrhea. This type difficulty was first described by Howland<sup>1</sup> in 1921. His observations were based on experienced clinical impressions. No other mention of this problem can be found until 1950 when Fox and Durham<sup>2</sup> reported sucrose malabsorption with sprue. It was not until 1958, when Durand<sup>3</sup> reported a patient with lactosuria and chronic diarrhea, and Holzel, Schwarz, and Sutcliffe<sup>4</sup> reported two cases of lactose intolerance associated with chronic diarrhea, that attention was really drawn to the problem and intensive research followed. Since this time, more than 60 cases of chronic diarrhea with disaccharide malabsorption and presumed or demonstrated disaccharidase deficiency have been reported.<sup>5-18</sup> In addition, cases of cystic fibrosis, celiac disease, and other malabsorption syndromes with associated disaccharidase deficiencies have been reported.<sup>19-21</sup> In this paper, two cases with chronic diarrhea and implied intestinal disaccharidase deficiencies will be presented, and methods of diagnosis and treatment will be discussed, who had had some pretibial edema and "black-out"

## Case Presentation

Case No. 1: This Negro male was delivered at home by a midwife to a gravida III para II mother

during her pregnancy. His birth weight was eight pounds (3,624 grams). He was started on an evaporated milk formula and did well until five weeks of age when he began to vomit feedings shortly after they were taken. Approximately 24 hours later he began having diarrhea. His formula was changed from evaporated milk to SMA<sup>®</sup> with no improvement. He was treated for pneumonia by his physician with penicillin but did not improve, and his abdomen became distended and the vomiting and diarrhea continued.

Physical examination on admission to this hospital at 55 days of age revealed a well-developed but poorly nourished infant in distress due to pain. His

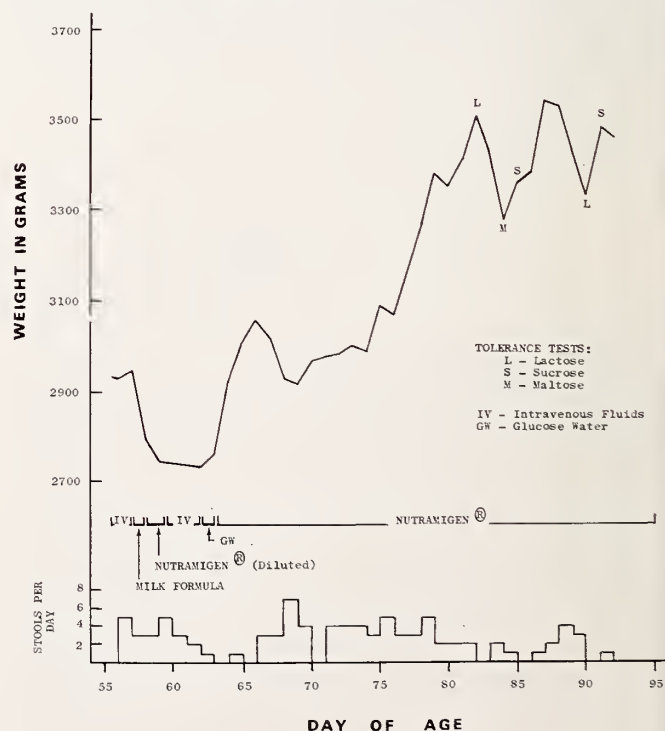


FIGURE 1

Graphic representation of the hospital course for Case No. 1.

Supported in part by Grant HD-01483-02.

SMA<sup>®</sup>—Wyeth  
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Olac<sup>®</sup>—Mead Johnson





FIGURE 2  
Graphic representation of the hospital course for Case No. 2.

weight was 2,925 grams, length 56 cm. and temperature 38° C. The subcutaneous tissue and muscular development were poor. Mucous membranes were pale. The abdomen was quite distended, but no organs or masses were noted. Bowel sounds were not heard. Feces were yellowish and watery with much flatus.

Initial serum electrolytes revealed sodium 128, potassium 3.5, chloride 99, and carbon dioxide 11 meq/L. Hemoglobin was 10.5 gm% with WBC of 27,800 with 72% segmented neutrophils. A spinal puncture was normal, and stool cultures grew normal flora. His initial course was complicated by ileus and inability to concentrate urine, presumably due to the severe total body deficit of potassium. After his condition was stabilized and water and electrolyte deficits were replaced intravenously, he was given Nutramigen® formula orally with no difficulty. Oral disaccharide tolerance tests were then performed revealing flat absorption curves as shown in Table 1. He was dismissed on Nutramigen® and has done well with good weight gain since.

### Case Report Two

This Negro female was delivered at home by a midwife after an uneventful pregnancy with a birth weight of five pounds (2,265 grams). She developed diarrhea at two days of age after being on evaporated milk formula. She was seen by her physician who changed her formula to 6:12 ozs. evaporated milk and water respectively. She contin-

ued to have frequent watery stools, and at eight days of age was started on Olac® formula with slight decrease in the number of stools. At 13 days of age she began vomiting as well as having greenish diarrheal stools. On the 16th day of age she began having grunting respirations and was admitted to this hospital on her 17th day.

Physical examination on admission revealed an extremely emaciated and dehydrated infant with a good cry in spite of her apparent condition. Her weight was 1,610 grams and temperature 36° C. Her skin was dry with no subcutaneous tissue. The fontanel and eyes were sunken, and mucous membranes were dry and pale. The abdomen revealed the liver edge 1-2 cm. below the right costal margin. No other organs or masses were felt. The feces were greenish and watery.

Initial hemoglobin was 14.9 gm% with WBC of 22,200 with 60% segmented neutrophils. Serum electrolytes revealed sodium 128, potassium 3.8, chloride 107, and carbon dioxide 10 meq/L. Stool cultures grew normal flora. She was treated with intravenous fluids initially. When any formula containing disaccharides was given, she promptly began having profuse diarrhea again, so she was given a disaccharide free diet for several days and then Nutramigen® which was well tolerated. Oral disaccharide tolerance tests revealed flat absorption curves (Table 1). She has done well since this time on Nutramigen®.



TABLE I  
DISACCHARIDE TOLERANCE TESTS

	Blood Glucose in mgm%			
	Fasting	30	60	90
Case No. 1				
Lactose	74	80	74	74
Maltose	67	116	108	93
Sucrose	72	102	111	75
Case No. 2				
Lactose	180	164	140	
Lactose (2 mo. later)	29	51	89	122
Lactose (4 mo. later)	38	81	66	63
Maltose	39	104	146	139
Sucrose	27	107	147	

Oral disaccharide tolerance tests were performed by giving 1.75 grams of the given sugar orally as a 10% solution after a six hour fast. To insure adequate liver glycogen stores, the tests were performed after several days of adequate dietary intake. Blood sugars were determined while fasting, just prior to administration of the sugar, and at 30, 60, and 90 minutes after ingestion. True serum glucose was determined by an ultramicro method.<sup>22</sup> Stool pH was measured using nitrazine paper.

Discussion

There are several possibilities to consider in a patient with a disorder of carbohydrate absorption. He may be overloading the intestinal capacity to metabolize the sugars or may have a reduced absorptive surface, as after intestinal resection, and therefore be dumping the sugar into the large bowel. Hyperperistalsis from any cause may carry the sugar through the small bowel before hydrolysis can occur. Other problems such as obstructed lymph flow may interfere with absorption, or there may be enzymatic deficiency due either to a congenital absence of the enzyme or secondary to loss of the microvilli as a result of mucosal damage from the chronic diarrhea.

The enzymes necessary to split the disaccharides, lactose, sucrose, and maltose, found in average diets, have been found to be located in the lining cells of the small bowel, specifically in the brush border portion of these cells.<sup>23-26</sup> Auricchio, Rubino, and Murset<sup>27</sup> have shown that, in the human fetus, maltase and sucrase activity can be demonstrated by the third fetal month, and that their activity has reached adult levels by the sixth to eighth fetal month. Lactase activity, however, becomes evident later and has reached maximal levels only at the end of normal gestation. It is likely that some infants may have a congenital absence of one of these enzymes.<sup>28-30</sup> Such patients presumably never develop function of the absent enzyme, whereas the patients

with an acquired deficiency secondary to mucosal damage will develop such activity.

Fermentative Diarrhea Produced

When a disaccharide is not acted upon by its appropriate enzyme and is passed into the ileocaecal and colon areas, it undergoes fermentation by the intestinal bacteria and the clinical picture of fermentative diarrhea is produced. These patients have vague abdominal complaints unrelated to defecation, abdominal distention, rumbling bowel sounds, increased flatulence, and produce profuse, foaming, thin, diarrhea usually containing fine mucus indicating small bowel origin. The feces are acid because of increased lactic and butyric acid content<sup>10</sup> and usually contains the offending disaccharide or increased monosaccharides following bacterial hydrolysis.<sup>31, 32</sup> If the infant is being breast fed, the lactic acid is not of help in diagnosis because these infants will have this present normally. The deficient child may also have mellituria and is usually retarded in growth with little to no subcutaneous tissue development.

The most direct way to investigate the patient with suspected disaccharidase deficiency is by small intestine mucosal biopsy with substrate incubation and actual enzyme determination.<sup>33</sup> This type study is not available in most hospitals, so disaccharide tolerance tests are used as indirect measures of activity. A normal rise in blood reducing sugar, expressed as glucose, during the tolerance is 50 mgm%.<sup>34</sup> If the tolerance test is abnormal, the component monosaccharides can be given, and if these are absorbed normally, the disaccharidase is presumed deficient. If the monosaccharides are not absorbed, the problem is one primarily of absorption and not enzymatic splitting of the disaccharide.

A Simple Test

The feces can be checked for sugar content and pH while the child is having diarrhea and during the tolerance tests. Nitrazine paper may be used to check pH, and a simple test for fecal reducing sugar has been reported by Kerry and Anderson:<sup>35</sup>

- 1. Liquid feces is collected on a plastic diaper, as absorption by a cloth diaper may give false negatives.
- 2. The test must be performed immediately to prevent bacterial utilization of the sugar with false low results.
- 3. One volume of feces is mixed with two volumes of water and 15 drops of the mixture is placed in a test tube to which an Ames Clinitest® tablet is added.
- 4. Reading is made as if a urine specimen: ¼ % or less is negative



$\frac{1}{2}$ - $\frac{1}{4}$  % is suspect  
Greater than  $\frac{1}{2}$  % is an abnormal amount  
of reducing sugar.

When the diagnosis has been established, removal of the offending disaccharide from the patient's diet results in cessation of diarrhea. The most commonly offending sugar is lactose, and this can be particularly troublesome because it is the sugar found in human breast milk, in cow's milk, and in all formulas made with a cow's milk base. There are formulas available with sucrose as the carbohydrate, and these, or formulas prepared which are free of all disaccharides, may be used while diagnostic tests are being performed. Usually, after a few weeks of treatment, the intestinal mucosa will return to normal, and the patient will be able to tolerate all foods well if the deficiency is due to intestinal mucosal damage. This ability can be checked by repeating the tolerance tests. Burke, Kerry, and Anderson<sup>31</sup> have recently shown by repeated small intestinal biopsy, however, that some patients require quite long periods of time before their disaccharidase activity returns to normal. In several of their patients activity did not return to normal until four to six months after treatment was started, and in one patient, activity was still abnormally low after ten months.

Two cases of chronic diarrhea with implied small intestinal disaccharidase deficiencies are presented, the disaccharidase deficiencies being implied by abnormal disaccharide tolerance tests. The literature regarding the subject is briefly reviewed, and clinical signs and symptoms mentioned. Methods of diagnosis and treatment are discussed, including a simple test for fecal reducing sugar determination.

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# EXTRAMEMBRANOUS PREGNANCY

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## ■ Report of two cases with a hypothesis of the etiology.

THE FIRST CASE of recognized extramembranous pregnancy was presented by Tarnier in 1895.<sup>1</sup> The rupture of the membranes, in this instance, was traumatic by the accidental insertion of a pin 12 cm long through the abdominal wall into the pregnant uterus at the fifth month. No abortion followed, but soon there was constant vaginal leakage of water and the pregnancy continued to seven and one half months (88 days after the rupture of the sac). Greatest of care was taken in the examination of the placenta which was 12 x 15 cm in overall diameter. It had a distinct central area of 6 x 7 cm with a border of placental tissue 2 to 3 cm wide, or a placenta circumvallata. From the margin of this central area arose the toughened and collapsed membranes which extended from the face of the placenta to a height of 18 or 20 mm and at the apex had a hole with thickened margin 35 mm in diameter. This sac when filled with water held 210 cc but the volume of the fetus displaced 980 cc. The diameter of the head at birth averaged 7 or 8 cm. The author proved that the fetus must have been outside of the membrane sac much of the time following its rupture. The fetus was born alive weighing 1,120 grams but was weak and died at four days of age. It showed signs of compression and apparently was dolichocephalic since the biparietal diameter was only 6.5 cm while the SOB was 7.4 cm.

### Interest Aroused

This recorded case aroused the interest of the French obstetricians who soon reported several other cases and Glaize,<sup>2</sup> 1899, composed the first monograph on the subject and introduced the name extramembranous pregnancy. Since then they have reported approximately 35 cases and have produced the following monographs: Gabrielle Tourrier,<sup>3</sup> doctorate thesis, 1912 and Apostolakis,<sup>4</sup> doctorate thesis, 1928.

The Germans early seem to have leaned toward the diagnosis of hydrorrhoea decidualis in these

cases but by 1899 began to present case reports of extramembranous pregnancy. Among these were Stoeckel, 1899, cited by Pfeilsticker,<sup>5</sup> by Muller, 1901, cited by Meyer-Ruegg,<sup>6</sup> and by Reifferscheid, 1901, cited by Buttrion.<sup>7</sup> Meyer-Ruegg<sup>6</sup> in 1904 compiled practically a monograph on extra-amniotic pregnancy and on extramembranous pregnancy. As such, the first German monographs on the latter subject were by Buttrion, of Wurzburg, 1912,<sup>7</sup> Amon of Erlangen, 1912,<sup>8</sup> and a year later in 1913 a very scholarly paper by Samuels<sup>9</sup> of Amsterdam, was written in Berlin, in which he summarized and tabulated 26 cases from the literature and speculated upon the relationship to placenta circumvallata.

Since 1914 with the report of two cases by Boero,<sup>10</sup> there has been great interest in the subject in South America. There, Sala<sup>11</sup> tabulated 23 cases in 1945. Only one case report by Siddall, in 1946,<sup>12</sup> was found in the United States literature. Only one other report in the English language was found which was a short paper by Erskine<sup>13</sup> of Great Britain in 1945.

### A Significant Paper

Recently, however, there appeared a significant paper in England by Bain, Smith and Gauld.<sup>14</sup> This did not mention extramembranous pregnancy but was on the subject of the condition of the newborn after prolonged leakage of amniotic fluid. The placenta was available in 11 of the 20 cases and in nine it was circumvallate. The authors reported the characteristics of the fetuses or infants to be similar to those of renal agenesis. They also reported a tendency to pulmonary hypoplasia in the infants that survived any length of time. Without doubt many of these cases were illustrations of extramembranous pregnancy.

### Case Reports

*Case One:* Slender Caucasian primipara, 18 years of age with height of 5 ft. 4 in. and normal weight of 97 lbs. was delivered of a premature female in-



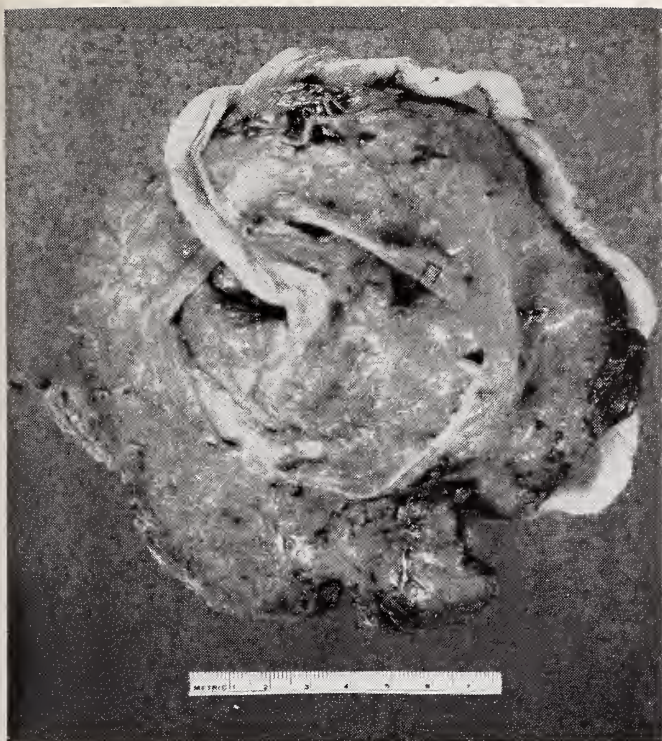


FIGURE 1

Placenta circumvallata with ancient rupture opening in the retracted membrane sac and revealing its smooth margin.

fant, born from frank breech presentation soon after entering the hospital on 5/20/65. She had been in labor approximately eight hours. The laboratory reports were as follows: hemoglobin 10.9, W.B.C. 26,000 (repeated 23,500), Seg. 88, lym 10, mono 2. Type O Rh pos.

The history revealed that her last menstrual period was 10/19/64. She had had vaginal spotting and bleeding off and on since the first month of pregnancy. In January she began vaginally to leak blood-stained clear fluid. This was more profuse when she was on her feet but continued during the night constantly until admission. She estimated the amount to be a pint each day and each night. It was at all times pinkish but less so at night. She had no pain but in the later stage could well feel the movements of the fetus. The membranes had been ruptured approximately 120 days.

The newborn female infant weighed 1,500 grams with an Apgar rating of seven. It cried and did quite well but within 24 hours a diagnosis of atresia of the esophagus was established and a gastrostomy operation was performed. There were minor malformities which were recorded by the orthopedic consultant (Dr. Stone): Simian feet, hallux varus, bilateral with transverse creases, possible hip dysplasia, bilateral, dolichocephalia. The pressure anomalies of this infant are quite typical of those described many times previously in association with extramembranous pregnancy. They are also quite similar to those of other instances in which there is a very small quantity of amniotic fluid.



FIGURE 2

Vertical histological section of agglutinated amnion and chorion at the margin of the scarred rupture opening outlined in Figure 1. Compare this with Figure 2, page 7, *Human Amnion and Chorion*, G. Bourne, 1962.<sup>15</sup> Note how the amnion curls up under itself at the ring orifice.

The placenta (Figure 1) which was delivered spontaneously weighed 365 grams and measured 13 x 13 cm. It was typically circumvallate with a border of 15 to 35 mm in width. The fetal sac comprising all of the available membranes came off of the inner margin of the border and was very reduced in sac volume and had a smooth edged hole of 7 cm in diameter as noted in the photograph (Figure 1). The margin when sectioned (Figure 2) shows the edge of the amnion curled under.

### Case Two

Slender Caucasian multipara, aged 23 years, height 5 ft. 3 in., normal weight 97 lbs. had her last menstrual period 1/4/65. Beginning in the second month of pregnancy, she had vaginal spotting off and on every two weeks or so, and she tired easily and had vague pains in the lower abdominal region. She felt life at four and one half months. In April she had an estimated 8 oz. of bright red vaginal bleeding and came to the hospital. She returned home but continued to spot and on May 14, after a day of rather strenuous housework, she had a gush of several ounces of pinkish water. This continued with several ounces each day and each night. There was an eight to ten inch spot on her bedding each morning.

On May 5, at 21 weeks of pregnancy and 21 days after the apparent rupture of the membranes, she went into a painful 21 hours of labor and was delivered of a five months female fetus with cephalic presentation. The fetus, weight 355 grams, C.R. length 160 mm foot length of 30 mm was stillborn or died very soon after birth. It had considerable ecchymosis and subdermal hemorrhage of the scalp and apparently was free of malformation except that the left foot turned markedly inward at the ankle.

The placenta, typically circumvallate (Figure 3), weighed 182 grams and had diameters of 10 x 11 with the central portion made by the reflected margin of 55 mm in diameter.



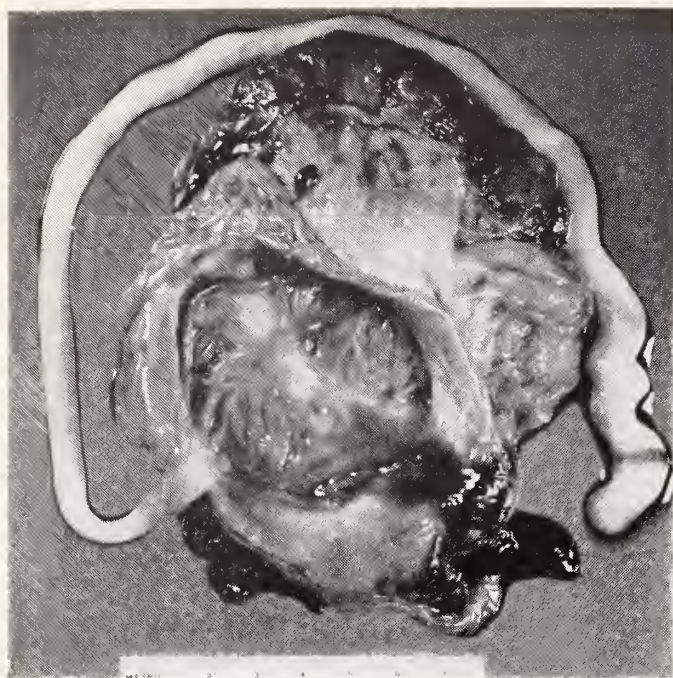


FIGURE 3

Circumvallate placenta with scanty remnants of fetal membranes still present.

The membranes, which were all present, had been ruptured, and a reconstruction of the sac revealed that the fetus must have been outside of the sac. The laboratory determinations in regard to the mother were as follows: blood type A Rh negative.

The added case report, No. Three, is presented because it had the striking clinical symptoms of extramembranous pregnancy but the fetus quite certainly was not outside of the fetal sac, which when distended in a tank of water held a volume of water equal to that of the fetus. The sac which apparently had been ruptured for a period of 77 days must have failed to retract but hugged the fetus and continued to enlarge along with the uterus and the fetus.

### Case Three

Caucasian multipara, aged 31, 5 feet 6 inches in height, normal weight 118 entered her fifth pregnancy with the last menstrual period, June 6, 1953. E.D.C. March 13, 1954. On November 17, about 6 months pregnant she had a sudden vaginal gush of clear fluid of a pint or more. Thinking that she was about to abort she continued to walk around in the daytime for two weeks. Then she remained in bed day and night employing two nurses to care for her. She continued, however, to leak fluid, intermixed with blood, and soaked several towels in 24 hours. This continued for about two months when, becoming anemic, she was taken to the hospital and given two pints of blood by transfusion. In the meantime the uterus increased in size and in due time the fetal heart tones were heard. There was no pain until late in January, 1954. In consultation, I made a tentative diagnosis of placenta circumvallata but at that

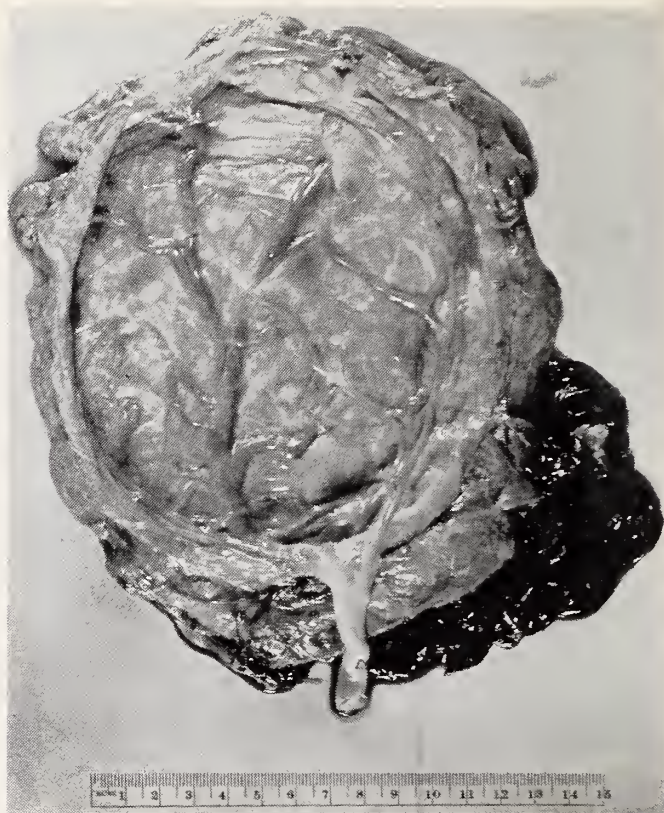


FIGURE 4

Placenta circumvallata of Case Report Three. The membranes which formed a sac containing the fetus had a water distended volume of 2,000 cc.

time I was not aware of the implications of the fluid discharge. On February 2, 1954, she suddenly went into labor and soon after arriving at the hospital was delivered of a 4 lb. 13 oz. male infant, from cephalic presentation. Although it did not breathe well, it survived and had no evidence of pressure malformities. The skin, however, had a senile wrinkled appearance. It had bilateral inguinal hernias and an umbilical hernia, all of which closed spontaneously by the use of truss devices. At six weeks of age the infant had an attack of bronchopneumonia. He did well, although he was late in talking (four years), and is now 11 years old and an A student in the fourth grade. He is small of stature but vigorous and healthy.

The placenta (Figure 4) weighed 550 grams and measured 15 x 18 cm. It was circumvallate with a margin of 1-2 cm in width. The membranes came off of the inner margin and made a sac which, when distended in a tank of water held 2,000 cc. The rupture opening was in the cervical region and not in the fundus. Evidently when the membranes ruptured in the sixth month of pregnancy, the fetus was not extruded through the rent as it is ordinarily. On the contrary, the uterine wall and the membrane sac apparently fitted closely to the fetus and expanded along with its growth.

Further history of the mother revealed that she first menstruated at 14 years of age and had a pro-



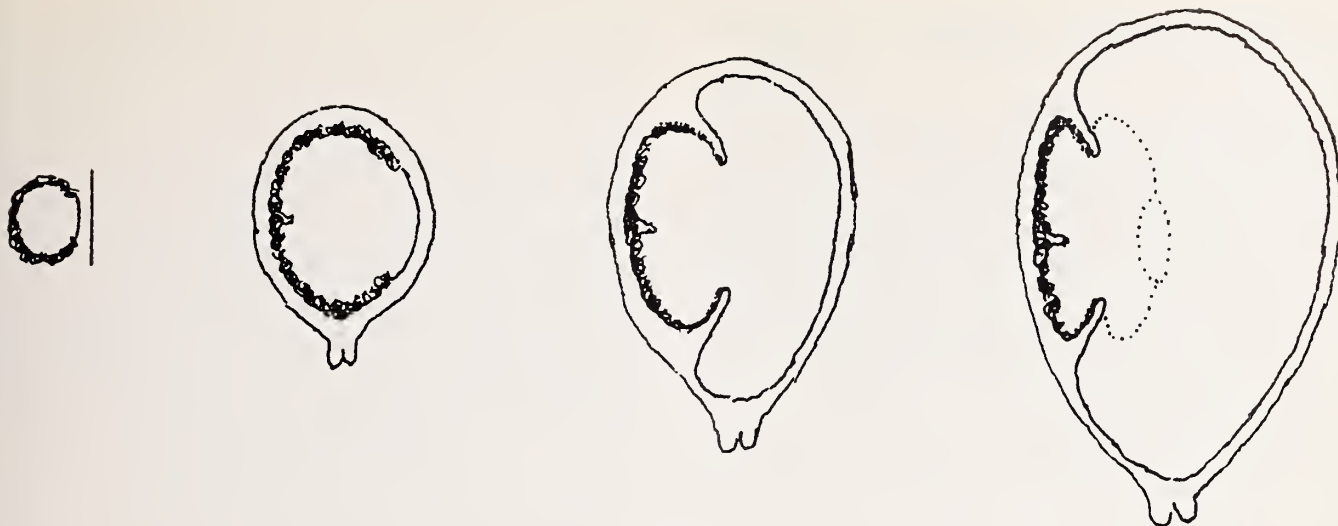


FIGURE 5

Except for the outline of the uterus this represents chorion only. Closely applied inside is amnion and closely applied outside is decidua. At the rim of this type of placenta, as it pulls away from the uterine wall the decidua is disrupted. This causes the hemorrhages attendant with placenta circumvallata

or, when the sac ruptures, with extramembranous pregnancy. The dotted line in the fourth part of the drawing represents the collapsed amnio-chorionic sac from which the fetus escapes into the bare uterine cavity.

longed flow of eight to ten days, with the most profuse on the first three days. She was married at the age of 21 and had her first child at 22. Her five pregnancies, other than this, were quite normal excepting the second one which ended at two months by spontaneous abortion. Since she bled previously in that pregnancy, there may have been an early circumvallate placenta. One of her other placentas was totally marginate.

### Similar Case Reports

In the literature of approximately 100 case reports of extramembranous pregnancy, there are two cases very similar to the preceding one. Apostolakis (Paris) 1928, (obs. X) described one as follows: a 35-year-old primipara lost water at the fourth month of pregnancy. The uterus was retracted but not painful. The water came intermittently in spite of constant bed rest. The amount was measured at times and found to be 400 to 500 ml on certain days. Labor ensued at near term and the fetus weighed 2,800 grams, alive and well-constituted. The placenta was borde (circumvallate). The ruptured membranes had a normal surface. It was impossible to find any other orifice except that through which the fetus had emerged. The author stated that it was possible that the membranes early-ruptured near the border of the placenta which permitted the fetus to develop in the membrane sac.

Meyer-Ruegg, 1939, described another one as follows: Twenty-year-old woman in the third month of gestation had considerable amount of bloody water discharge without pain. This started suddenly with a gush. Examination at the fifth month revealed that the uterus was small for the period of gestation. The discharge situation continued until

about the seventh month when labor ensued and the fetus was delivered from cephalic presentation and showed no abnormalities. It weighed 1,680 grams, was feeble and soon died.

The placenta measured 12 x 13 cm and was entirely normal without trace of margination or circumvallation. There was, in the membrane sac which had contained the fetus, a large hole, showing by its fused and undermined margin, that it had been made earlier in gestation, dated 64 days before labor.

Although, in these three instances, the clinical symptoms were identical to those in extramembranous pregnancy, none could be classed as such. It is interesting to note that the fetus was relatively undamaged in these cases, although the membranes had been ruptured 77 days in one case, 120 days or more in the second and 64 days in the third.

Most of the authors of the nearly 100 case reports in the world's literature have been content to describe the symptoms, pathology and outcome, including malformations of the fetus. Few have presented etiological hypotheses. In fact none could be given without a clear understanding of placenta circumvallata.

### A Hypothetical Venture

Based upon the fact that extramembranous pregnancy results almost invariably from a placenta circumvallata, the latter must have some inherent characteristics for its production. Following is a venture as to a hypothesis in regard to these peculiarities. It has been suggested, although not generally accepted, that placenta circumvallata must arise from a relatively deep ovular-decidual implantation. If that is the case, then the gestation sac, in the early stages, is composed in area of more than one-half and up



## Extramembranous Pregnancy / *Torpin*

to three-quarters of its wall by placenta. The original membranes in these cases are much less in area than in the normal. The amnion and chorion do not have blood supply, *per se*, but depend for such upon the overlying decidua. In normal pregnancy, the membranes at all times are of such extensive area that the necessary stretching to cover the fetus at term seldom is associated with spontaneous rupture, and if they are ruptured by trauma, abortion usually promptly occurs. In placenta circumvallata, on the other hand, the original membranes (especially chorion) are very restricted in area and the subsequent stretching must have a tendency, at times, to produce rupture.

In addition, the circumvallate placenta seems to have a proclivity to fail to separate and to be extruded from the uterine cavity after collapse of the sac. This is demonstrated not only in extramembranous pregnancy but also in the production of Breus subchorial hematoma mole. No doubt, this is due to its early abnormally extensive placental area attachment to the uterine wall (Figure 5).

It is contended that the combination of these two prerequisites, and these only, result in the rare occurrence of extramembranous pregnancy.

### Accidental Situations

There are two more or less accidental situations in respect to the fetal membranes, *per se*. (1) The amnion alone may rupture, giving rise to extra-amniotic pregnancy, with the fetus surviving in the intact chorionic sac. (2) Both chorion and amnion may rupture. Usually this results in abortion, which in the case of placenta circumvallata, may be delayed for even several months and is seen as an extramembranous pregnancy. This obstetric accident is possibly less common than number one (1).

The dangers to the fetus vary in these two situations. In rupture of the amnion, only, there may be pressure exerted upon the fetus soon after because of the presumed absorption of the amniotic fluid by the amnion-denuded naked chorion. However, there is evidence<sup>16, 17</sup> that the chorion subsequently becomes smoother and tougher and certainly is able to retain the fluid quite as well as the amnion. The fetus then is subject to entanglement of its protruding parts with the amniotic debris and strings (especially those detached from the chorion). Rarely it may swallow the free end of a string and thus may hold its head in contact with the placenta where it may grow fast.

On the other hand, in extramembranous pregnancy, the absence of fluid allows considerable pres-

sure directly upon the fetus and restricts its active motion so that it does not become entangled with the membrane strings which may be present. The defects in general are similar to those that have been described by Potter<sup>18</sup> and others in respect to oligohydramnios of renal agenesis—to wit: external ears plastered flat to the head with or without dolichocephaly, bowing of the legs, dysplasia of the hip joints, malformed feet or hands. Likewise, they may have some hypodevelopment of the lungs. In the majority of the reports, the presentation of the fetus at the time of delivery has been breech.

### In Respect to Management

A few words may be added in respect to the management of these cases. It seems from the reports in the literature that the danger of infection is not great. The hazard to the mother is from the hemorrhage often attendant upon placenta circumvallata. The prognosis of the fetus is much graver. There is a very high abortion rate and prematurity is the rule in those that continue in pregnancy. The French put much faith in bed rest. Possibly if the foot of the bed is elevated less fluid might escape from the uterus. This might be of value to the fetus. Certainly the attendant should check, from time to time, the hemoglobin, and this should be corrected by iron and transfusions as indicated. A close watch on the mother's temperature and leukocyte count may give an indication for the proper use of antibiotics. For the sake of the record, scientific accuracy, and a proper appreciation of the management, the identity of the fluid should be ascertained early by proper tests. If, as is quite common in these cases, the fetus is born viable but soon dies, it is of academic importance to weigh the lungs and to make microscopic studies as to the development. It seems to be possible that in these cases, as in those of renal agenesis, there may be delayed maturation of the fetal lungs.

### Prognosis for Mother and Child

Since the prognosis for the mother is good and, for the fetus not bad, if the pregnancy can be maintained to or near the eighth month, every effort should be extended to this outcome.

Prognosis for the life of the infant is better in extra-amniotic pregnancy, but the prognosis for permanent damage is less in extramembranous pregnancy. The malformities of the latter are of pressure etiology and if the infant survives, they are usually correctable. On the contrary, in extra-amniotic pregnancies the amputations, if present, present incorrigible deformities, which usually may be limited to distal extremities, fingers and toes. In extra-amniotic pregnancy the chief danger to the life of the fetus is from entanglement of the umbilical cord



by the strings. There are possibly 20 case reports of such in the literature.

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GEORGIA-CORNELL AUTOMOTIVE CRASH INJURY  
PROGRAM PUBLISHES FINDINGS OF TWO-YEAR STUDY

The second two-year data collection program jointly sponsored and undertaken by the Georgia Highway Patrol, the Georgia State Board of Health, the Medical Association of Georgia and the Georgia Hospital Association was concluded on November 30, 1965.

The two programs have produced a total of about 2,600 cases reported and investigated by the participating agencies in Georgia. The following table shows the volume of cases reported from the various areas of study for the designated period of time during the second program.

Georgia—Second Program—1963-1965			
Period	Study Area	Date	Cases Reported
1st	Troop D	12/31/63- 5/31/64	158
2nd	Troop B	6/ 1/64-11/30/64	193
3rd	Troop C	12/ 1/64- 5/31/65	142
4th	Troop A	6/ 1/65-11/30/65	279
Total			772

The cases submitted by Georgia represent a most important addition to the overall interstate Cornell ACIR volume of cases. The Georgia data has been utilized in many of the studies and reports recently produced by this research project.

Cooperation of the various Georgia state agencies and their members has been excellent throughout the full period of study. ACIR accident reports and photographs submitted by members of the Georgia Highway Patrol have been outstanding in every respect. Accurate and complete reporting of ACIR medical information on hundreds of injured occupants reflects the excellent cooperation of the numerous physicians and hospitals and their organizations, the Medical Association of Georgia and the Georgia Hospital Association. The work performed by the Georgia State Board of Health in coordinating the medical aspects of the program, under the direction of John H. Venable, M.D. and staff was outstanding, particularly when local follow-up to obtain medical reports was necessary.

Preliminary Findings

A total of 2,600 injury or property damage cases have been reported to ACIR. To date, over 90% of the cases have been analyzed, coded, and the data represented on IBM punch cards.

Early tabulations show that 40% of the injury-producing accidents were single car and 60% were multiple vehicle accidents. Twelve percent of the accidents involved single cars in rollovers.

In the first Georgia-ACIR program, completed in 1959, fewer than 1% of the cars reported had seat belts installed. In the program that terminated in November 1965, 27% of the cars contained seat belts. About 27% of the occupants who had seat belts in the first program used them. During the second study program about 31% of the occupants who had belts were using them when an accident occurred. It should be noted that although the percentage of available belts used increased very slightly (from 27% to 31%), the actual use of seat belts increased greatly because seat belt installation increased from 1% to 27%.

During the first two-year program, about 9% of the occupants in injury accidents were ejected from the car. During the second program, about 7% of the occupants in injury accidents were ejected. This observation reflects the findings in recent ACIR door latch studies which showed that the improved latches on late model cars reduced door opening and associated ejection. The hazards of ejection are illustrated by the fact that, in Georgia, 32% of the ejected occupants sustained serious or fatal injuries while only 9% of the non-ejected occupants suffered these injuries.

Automotive Crash Injury Research, Cornell Aeronautical Laboratory of Cornell University, expresses sincere appreciation to Colonel H. Lowell Conner and the Command staff and patrolmen of the Georgia State Patrol; John H. Venable, M.D., Director of the Georgia Department of Public Health, also A. Faegin Parrish and staff who served as Medical Coordinator; Mr. Milton D. Kreuger, Executive Secretary, and all the members of the Medical Association of Georgia; also Mr. Glenn M. Hogan, Executive Director, and all member hospitals of the Georgia Hospital Association.

With the current increased interest in highway safety, we are hopeful that we may again have the continued cooperation of these well-organized and experienced Georgia state agencies in another Georgia-Cornell Automotive Crash Injury Research study in the very near future.



# RHEUMATIC FEVER WITHOUT CLINICAL EVIDENCE OF CARDITIS: A REAPPRAISAL

Ben L. Bivins, B.S.\*

Nanette Kass Wenger, M.D. *Atlanta*

- Sixty-seven patients followed in the cardiac clinics of the Georgia Heart Association were the subjects for this study.

**P**ROPORTIONALLY more rheumatic fever without clinical carditis occurs today, 56% during 1951-58 versus 35% during 1935-42.<sup>1</sup> A decline has also been reported<sup>1, 2</sup> in the incidence and in the severity of acute rheumatic fever. Acute rheumatic fever in the adult age group is even more commonly characterized by the absence of clinical carditis.<sup>3</sup> Rheumatic fever without clinical evidence of carditis thus warrants a careful reappraisal as regards the pattern of the acute episode, the probability and consequences of rheumatic fever recurrence, and the necessity and efficacy of chemoprophylaxis.

## Review of the Literature

In 1937, Roth<sup>4</sup> evaluated 488 children with acute rheumatic fever; 220 children had polyarthritis as the sole major manifestation during the initial episode. One hundred and forty-nine of these 220 children (67.7%) had recurrent rheumatic fever, and in 49 (32.9%) the recurrence was characterized by carditis, either isolated or associated with polyarthritis. Sixty-eight recurrences (73.9%) were recorded among the 92 children who had chorea during their initial rheumatic episode; nine of these recurrences (13.2%) were characterized by carditis, either alone or in association with chorea. In this study, however, the criteria for carditis were not defined, and most of the children were observed by the authors either only with the rheumatic recurrence or some years following the initial attack of acute rheumatic fever.

Boone and Levine,<sup>5</sup> in 1938, reviewed 166 cases classified as having "potential rheumatic heart disease," i.e., a history of acute rheumatic fever, either without a cardiac murmur or with a grade I apical systolic murmur. Five of these patients (3.0%) later developed recognizable valvular disease, two following the initial attack and three with subsequent episodes of acute rheumatic fever. Many of these patients had not been evaluated by the authors during the acute illness.

In 1948, Ash<sup>6</sup> reported a ten-year follow-up study of 588 children with prior acute rheumatic fever. Of the 219 patients without clinical evidence of carditis during the initial attack, 51 (23.3%) later had evidence of valvular disease. In 43 of these patients (84.3%) significant murmurs appeared during rheumatic recurrences, while in eight patients (15.7%) the appearance of the murmur of mitral stenosis was unassociated with overt signs of acute recurrent rheumatic fever.

Feinstein and DiMassa<sup>7</sup> described 359 rheumatic children at Irvington House who were evaluated monthly for at least two years; 178 patients had no clinical evidence of valvulitis during the initial attack of rheumatic fever. None of these 178 patients developed valvular disease during an average follow-up of 4.7 years (2-9 year range). The authors concluded that if valvulitis was absent during the acute attack of rheumatic fever, there was "reasonable reassurance that heart disease will not develop as a late sequel."

In 1960, Feinstein and Spagnuolo<sup>8</sup> reviewed rheumatic fever recurrences in 71 patients without valvulitis during the initial acute rheumatic attack. Sixty-one patients (86%) had a total of 129 recurrences of rheumatic fever without valvular involve-

*This study was supported by funds from the Cardiovascular Disease Control Center of the Georgia Department of Public Health, Atlanta.*

\*Fourth-year medical student, Emory University School of Medicine.



ment. The authors questioned whether diastolic murmurs were not initially missed in the ten patients (14%) who had valvulitis with subsequent rheumatic attacks.

Feinstein and Spagnuolo,<sup>9</sup> in 1962, reported recurrent rheumatic fever in 27 patients who had no clinical evidence of carditis during the initial attack of rheumatic fever. Twenty-five patients had no carditis with the rheumatic recurrence and two patients had evidence of pericarditis. None of these patients developed valvulitis during the recurrent episode of acute rheumatic fever.

In 1963, Kuttner and Mayer<sup>10</sup> reviewed rheumatic fever recurrences in 50 patients without clinical carditis during the initial attack of rheumatic fever. Thirty-three patients had no carditis during recurrent episodes, four had questionable carditis (soft apical systolic murmur), and 13 had documented carditis. Of the 13 patients with carditis during the rheumatic recurrence, six had residual valvular disease and seven had no evidence of valvular disease from 2-18 years later.

Feinstein et al,<sup>11</sup> in 1964, described 12 rheumatic recurrences in 177 patients without carditis in preceding unequivocal attacks of acute rheumatic fever. Possible carditis was observed in only two of these patients with recurrent rheumatic fever, without residual valvular damage.

In 1965, Leonard and Wenger,<sup>12</sup> reviewed 265 cases of rheumatic fever without clinical carditis at the Grady Memorial Hospital Cardiac Clinics. In their average follow-up of five years, 19 patients (7.2%) had recurrent rheumatic fever; only one of these patients was apparently receiving regular chemoprophylaxis. Only one patient developed carditis during a rheumatic recurrence, characterized by pericarditis (friction rub) and myocarditis (AV dissociation), without residual valvular damage; the recurrent episode occurred 18 years after the initial rheumatic fever attack.

## Material and Methods

The study group consisted of patients followed in the Georgia Heart Association cardiac clinics\* who had acute rheumatic fever without clinical evidence of carditis. The patients selected had well-documented episodes of acute rheumatic fever without clinical carditis and had been evaluated for at least one year following the acute illness.

Diagnosis of the acute episode of rheumatic fever was made in accordance with the modified Jones Criteria,<sup>13</sup> and carditis was defined as outlined by the American Heart Association.<sup>13</sup> Chemoprophyl-

axis was administered as recommended by the American Heart Association.<sup>14</sup>

The study group included 67 patients, ranging in age from three to 31 years, with an average age of 14 years. The age distribution by decades at the time of the study was: 0-10 years, ten patients; 11-20 years, 53 patients; 21-30 years, three patients; and 31-40 years, one patient. There were 36 males, 27 white and nine Negro; and 31 females, 23 white and eight Negro.

## Results

### *Major manifestations*

Of the major criteria used for the diagnosis of acute rheumatic fever, only polyarthritis and chorea are represented in this study group; 51 patients (76%) presented with polyarthritis and 16 patients (24%) with chorea. No patient had both chorea and polyarthritis. No patient had either erythema marginatum or subcutaneous nodules.

### *Age at onset of acute rheumatic fever*

The average age at onset of acute rheumatic fever was 9.5 years, with an age range of three to 27 years. All but one patient had the initial rheumatic attack before age 18. The duration of follow-up subsequent to the last acute episode of rheumatic fever varied from one to 11 years, with an average follow-up of three years.

### *Seasonal incidence of acute rheumatic fever*

The percent distribution by months of the onset of acute rheumatic fever was: January—18.7%; February—8.0%; March—5.3%; April—8.0%; May through August—6.7% each month; September—8.0%; October and November—6.7% each month; and December—12.0%.

### *Chemoprophylaxis*

Fifty-five patients received sulfadiazine prophylaxis, but 20 took their medication irregularly. Eighteen patients received penicillin prophylaxis, with four taking the medication irregularly. Ten patients had been changed from sulfadiazine to penicillin prophylaxis or vice versa, usually because of drug sensitivity. Chemoprophylaxis had not been prescribed for four patients at any time; an additional four patients received chemoprophylaxis only after the recurrent episode of rheumatic fever. A total of 28 patients (42%) were therefore not receiving chemoprophylaxis regularly.

Patients were followed at the cardiac clinics for 1-12 years, with an average follow-up of four years. This represents a total of 255 patient-years of follow-up: 117 patient-years on regular sulfadiazine prophylaxis, 57 patient-years on sulfadiazine prophylaxis taken irregularly, 32 patient-years on regular penicillin prophylaxis, five patient-years on peni-

\* Athens, Augusta, Columbus, Dalton, Gainesville, Macon and Savannah, Georgia Cardiac Clinics; the Giddings Clinic at St. Joseph's Infirmary in Atlanta, and the Crippled Children's Cardiac Clinic in Atlanta. The Georgia Heart Association Cardiac Clinic patients at Grady Memorial Hospital were reviewed separately and are not included in this study.



## RHEUMATIC FEVER / Bivens & Wenger

cillin prophylaxis taken irregularly, and 44 patient-years without prescribed chemoprophylaxis.

### *Rheumatic recurrences*

Ten patients (15%) had a single recurrence of rheumatic fever and one patient (2%) had two recurrences. None of the patients with recurrent rheumatic fever was taking chemoprophylaxis regularly at the time of the recurrence. Five patients taking sulfadiazine prophylaxis intermittently each had one rheumatic recurrence; two patients taking penicillin prophylaxis intermittently each had one rheumatic recurrence; and four patients who had not been prescribed chemoprophylaxis had a total of five rheumatic recurrences. A total of 39% of patients not receiving regular chemoprophylaxis had recurrent acute rheumatic fever.

The average age of the recurrent rheumatic fever group at the time of the initial attack of rheumatic fever was eight years, 1.5 years younger than the average age for the total study group. The average age at the time of rheumatic recurrence was 12 years, with an age range of 6-18 years; the interval between attacks ranged from 1-8 years, with an average of four years. Three of the recurrent episodes exceeded a five-year interval after the initial rheumatic fever attack. Patients in this "recurrent" group have been followed for an average of three years subsequent to the last acute episode of rheumatic fever.

All 12 rheumatic fever recurrences were of a mimetic nature, four presenting as chorea and eight as polyarthritides; the one patient with three rheumatic fever episodes had chorea as the sole major manifestation with each attack.

### *Chorea group*

The 16 patients with acute rheumatic fever without clinical carditis who had chorea as the major manifestation were analyzed separately to see if they differed from the total study group. This "chorea group" included ten males, seven white and three Negro; and six females, four white and two Negro. Seven of these patients received regular sulfadiazine prophylaxis; three took prophylactic sulfadiazine irregularly; four received penicillin prophylaxis regularly; and three had not been prescribed chemoprophylaxis. One patient had been changed from sulfadiazine to penicillin prophylaxis because of drug sensitivity. Three patients (19%) in this group had a total of four rheumatic fever recurrences; two females had one recurrence each and one male had two recurrent episodes. All recurrences were in the patient group taking chemoprophylaxis irregularly or those not prescribed chemoprophylaxis; this represented a 50% recurrence rate for the group not receiving chemoprophylaxis regularly.

The average age at onset of acute rheumatic fever in this study group, 9.5 years, is similar to that of other reported studies.<sup>15</sup> Seventy-six percent of the patients presented with polyarthritides and 24% with chorea as the sole major manifestation for diagnosis; this distribution is similar to other groups of rheumatic fever patients reported.<sup>15</sup>

Although the peak incidence of acute rheumatic fever was during December and January, a substantial proportion of acute episodes occurred each month of the year. This supports the necessity of chemoprophylaxis throughout the year.<sup>14</sup>

There was no recurrence of acute rheumatic fever in the patient group receiving chemoprophylaxis regularly. There was a 39% recurrence rate in the patient group not receiving regular chemoprophylaxis. This confirms the efficacy of regular chemoprophylaxis in the prevention of rheumatic fever recurrences.<sup>14</sup>

Although the average interval between the initial acute rheumatic fever episode and the rheumatic recurrence was four years, there was a range of 1-8 years; three (25%) recurrent episodes occurred more than five years subsequent to the initial attack. This re-enforces the recommendation<sup>14-16</sup> that chemoprophylaxis should be continued for longer than five years subsequent to the acute rheumatic episode.

No patient spared carditis with the initial episode of acute rheumatic fever developed carditis with a recurrent attack, i.e., all recurrences were of a mimetic nature. This is in agreement with the reports of Feinstein and Spagnuolo,<sup>8, 9</sup> Feinstein et al,<sup>11</sup> and Leonard and Wenger.<sup>12</sup>

The group of patients with chorea as the sole major manifestation of acute rheumatic fever did not differ significantly from the total study group.

## Summary

1. There was a 17% recurrence rate of acute rheumatic fever among 67 patients who had an initial episode of acute rheumatic fever without clinical evidence of carditis.

2. All rheumatic recurrences were mimetic, i.e., no patient spared carditis with the initial episode had a rheumatic recurrence characterized by carditis.

3. All 12 rheumatic recurrences were in the patient group *not* receiving chemoprophylaxis regularly, representing a 39% recurrence rate for this group.

4. Rheumatic recurrences were encountered from 1-8 years subsequent to the initial acute episode and occurred throughout the months of the year.

There is a significant rheumatic fever recurrence rate among patients who have had acute rheumatic fever without clinical evidence of carditis. The re-



currences are mimetic in nature. Rheumatic fever recurrences can be prevented by long-term, year-round chemoprophylaxis.

ACKNOWLEDGEMENTS

We are indebted to the staff of the Georgia Heart Association; to the staffs of the Georgia Heart Association Cardiac Clinics; to Miss Carol Miller, secretary of the Grady Memorial Hospital Cardiac Clinics; to Mrs. Lucille Langford, R.N., Grady Memorial Hospital Cardiac Clinics; and to Miss Paula Bogren and Mrs. Nancy Bivins, secretaries in the Department of Medicine, Emory University School of Medicine for their help in the preparation of this paper.

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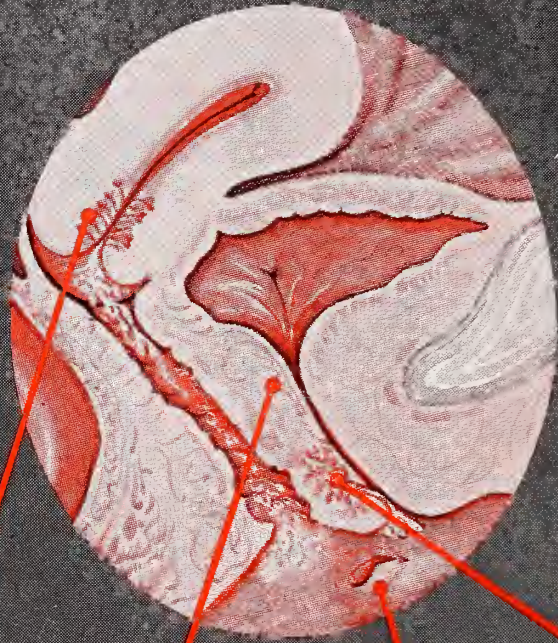
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"GEORGIA HEART HOUR"  
PRESENTS JUNE PROGRAM

The ninth in the current series of television programs presented by the Georgia Heart Association for physicians will be seen June 6-7 on the Georgia Educational Television Network. It is entitled "Cardiac Arrhythmias." Guest Faculty includes Charles K. Friedberg, M.D., Chief, Department of Cardiology, The Mount Sinai Hospital and Thomas Killip, III, M.D., Assistant Professor of Medicine, Cornell University Medical College.  
A part of the "Georgia Heart Hour" series, this program will be telecast from 10:30-1:30 p.m., Monday, June 6, and repeated at the same time on Tuesday, June 7.



Flagyl destroys trichomonads



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No topical treatment can



**Flagyl**<sup>®</sup>  
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Flagyl eliminates the difficulties and frustrations that have long attended the treatment of trichomonal infection.

These difficulties arose mainly from:

- 1) *the failure of any previously known agent to destroy the protozoan in para-vaginal crypts and glands;*
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The introduction of Flagyl removed both of these long-standing deficiencies. Hundreds of published investigations in thousands of patients have confirmed the ability of Flagyl to cure trichomoniasis.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced a cure rate of up to 100 per cent in large series of patients.

Nothing cures trichomoniasis like Flagyl.

### **Dosage and Administration**

In *women*: one 250-mg. oral tablet t.i.d. for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.

In *men*: in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

### **Contraindications**

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

### **Precautions and Side Effects**

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

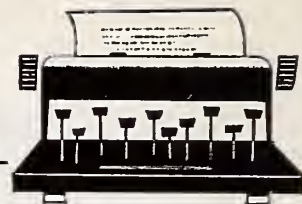
### **Dosage Forms**

Oral—250-mg. tablets/Vaginal—500-mg. inserts

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*Research in the Service of Medicine*





## Let's Take a Look at Your AMA Education And Research Foundation Activities

*"Just what is this AMA-ERF? What are their projects? Do they just solicit funds for the American Medical Association? How is this money used? Tell me about your AMA-ERF, Doctor."*

THE AMERICAN MEDICAL ASSOCIATION EDUCATION AND RESEARCH FOUNDATION is four years old and has three main programs that reach out to touch the practice and performance of medicine in the future.

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A glance at the record of the AMA Education and Research Foundation reveals significant accomplishment. The Foundation has

- transmitted more than \$1 million a year from physicians and their wives in unrestricted funds to medical schools;

- guided more than \$3 million from physicians and industry into \$30 million in loans for medical students, interns and residents;

- created the mechanism that channels funds into research on smoking and health;

- supported the Summer Institute for Medical Journalism which aims at increasing the writing and editing abilities of young physicians;

- established a program in bequests to medical research—a service to bankers and lawyers in guiding their clients' bequests;

- set up the mechanism to accept small contributions to research that by themselves would purchase little, but which when pooled become capable of sponsoring research projects; and

- in the last year built and opened the Institute for Biomedical Research—an exciting venture in basic biomedical research.

What is ahead for the AMA Education and Research Foundation? That depends on each physician. The success of these programs is in your hands, doctor—in the hands of the physicians who endorse the Foundation.

## Astwood and Thyroid Cancer

*I shall be telling this with a sigh  
Somewhere ages and ages hence:  
Two roads diverged in a wood, and I—  
I took the one less traveled by,  
And that has made all the difference.*

Robert Frost\*

\* Excerpted from "The Road Not Taken," by Robert Frost, *Complete Poems of Robert Frost*. Holt, Rinehart and Winston, Inc.

THE NEWS of Dr. E. B. Astwood's appearance at the recent Atlanta Graduate Medical Assembly provoked a remark with undisguised hostility, "What! Is that guy still around?" Dr. Astwood is indeed around, and he continues to upset some of us with his bland admonitions. Others of us become ruffled when he deprecates the tendency of surgery to dominate the treatment of thyroid diseases—a carry-



over from the days of the first dramatic successes of surgical treatment of thyrotoxicosis.

In Astwood's words:

"Although a much clearer understanding of the thyroid gland, derived from extensive investigation over the past 20 years, has yielded a physiological basis for the treatment of thyroid disease, the mechanical approach still hampers understanding and progress."\*\*

### Ideas Belie the Man

While Astwood's ideas are provocative, he himself is most gentle and self-effacing in his presentation. For instance, when a question came up concerning the use of thyroid scans, Astwood admitted that he employs no expensive radioactive scanning apparatus. Stating that he applied a simple sensing device first over one lobe then the other, Astwood assumed a look of mock diffidence—as if to say that although he has disdain for gadgets he has no strong criticism for those who are fascinated by gadgetry. In fact, radioactive thyroid scans as commonly performed, though technically fascinating, are very often worthless without proper clinical diagramming.

As a lecturer, Astwood's most engaging quality is his air of imperturbability, betrayed at times by some beads of perspiration on his brow. He is most anxious not to perturb in turn; however, his pet theme is unfortunately a highly provocative one. He would make a myth of the commonly accepted view that thyroid cancer may be prevented by the removal of solitary thyroid nodules. His logic is plain enough: If the commonly accepted figure for the incidence of cancer in solitary nodules (4% to 24%) is correct, then thyroid cancer should be a common occurrence. In fact, thyroid cancer is one of the least encountered lesions. Its incidence as a cause of death is 0.6 per 100,000, about as common as death from diphtheria in this country. Obviously there is something wrong with the criteria used in classifying thyroid cancers. The morphologic configurations which are of tremendous prognostic sig-

nificance when seen in other organs seem not to apply to the thyroid gland.

Clinically, the most commonly encountered lesion called cancer is the papillary tumor, one which rarely causes metastasis and which is often dependent on thyroid stimulating hormone. The next most common tumor is rarely found first in the neck—rather it is usually discovered by finding a distant metastasis. In this case the thyroid is normal to palpation or the site of an unimpressive goiter. The least common tumor is so highly malignant that widespread metastasis would have occurred by the time a diagnosis is made.

In the instance of the papillary tumor, Astwood recommends taking advantage of its thyroid stimulating hormone dependence by suppression pituitary production of this hormone with oral doses of thyroid hormone. This approach may make disfiguring surgery unnecessary. Surgery would be of no use in preventing the occurrence of the second and third instances of spread.

Astwood views single nodules as well as nodular goiters as a response of the thyroid gland to excessive thyroid stimulating hormone activity. According to this rationale, he has treated a large series of patients with diffuse and nodular goiters with suppressing doses of thyroid. Over half of the patients with single nodules showed a moderate to complete response to this treatment. Results were even better in diffuse and nodular goiters, 67% to 76% respectively. In some cases the treatment must be carried on for at least 18 months or better before results are noted.

In this field of study, in which the alternatives are not clear and in which fear of consequences leads to drastic action, a rational approach is indeed welcome. If one is unwilling to abandon an approach which, if mechanical, is at least in vogue, he cannot be blamed; however, admiration rather than feelings of vague threat would be more appropriate for a man who has courage to explore alternative possibilities. We should all profit from the experience of the man who took the road "less traveled by."

*Benjamin D. Saffan, M.D.  
1211 West Peachtree Street, N.E.  
Atlanta, Georgia 30309*

\*\* Astwood, E. B.: "Management of Thyroid Disorders." *J.A.M.A.* 196:585-9, 9 Nov. 63.

## Two-Year Nursing Programs Approved for Georgia

GRADUATES of associate degree nursing programs administered by junior colleges, colleges or universities may now be registered as graduate nurses (R.N.'s) in Georgia. Following an intensive study

of nursing education, the Board of Regents of the University System of Georgia recommended passage of an amendment to the law governing the practice of nursing. The amendment (Senate Bill 114), en-



dorsed by major health groups, including the Medical Association of Georgia, was passed by the 1966 General Assembly. Governor Carl Sanders signed the amendment into law on March 10, 1966.

### Two Institutions

The Board of Regents has approved the establishment of two-year associate degree nursing programs at two University System institutions, Armstrong State College in Savannah and Abraham Baldwin Agricultural College in Tifton. These programs will be initiated in the fall of 1966. It is anticipated that additional programs will be approved in the future.

Associate degree nursing (ADN) programs were developed in the early 1950's as a result of a thoughtfully planned and carefully executed experiment. The success and acceptability of these earlier programs was evidenced by the existence of more than 120 programs in approximately 30 states in 1964. The National League for Nursing, in recognition of these programs, established a separate board for the accreditation of ADN programs in 1957.

### Patient Care

The ADN program represents a highly structured concentrated curriculum oriented to patient care. It is *stripped of all service responsibilities, apprenticeship characteristics and unnecessary repetitive learning*. Students can devote their energies to the best possible learning of nursing and are called upon to do intensive and concentrated studying and learning during the two-year period.

The length of associate degree programs usually falls between two academic years and two calendar years. College credits earned in these programs include approximately one year of general education (chemistry, biology, English, mathematics, anatomy, physiology, psychology, etc.) and one year of clinical instruction. Clinical instruction is patient centered and is taught in hospitals and other health agencies. While the division of instruction in terms of credits is often about equal between college courses and clinical instruction, the clinical instruction is spread over the entire two years of the program. Students spend several hours each week in hospitals. Clinical instruction is usually divided into four clinical areas: fundamentals of nursing, medical-surgical nursing, maternal and child care nursing, and psychiatric nursing.

### Proven on Examination

A study of associate degree nursing program graduates published by the National League for Nursing states that "... the graduates of associate degree programs were equal or slightly superior to the total group of candidates for licensure with regard to abilities that are measured by the licensing examination."<sup>1</sup> More recent figures released by the National League for Nursing substantiate the above statement.

Associate degree nursing programs are graduating students prepared to give care to patients as *beginning staff nurses*. The development of these programs in Georgia holds the promise of increasing our supply of competent registered nurses.

<sup>1</sup>Report on Associate Degree Programs in Nursing, National League for Nursing, New York, page 29.

## 1966 CALENDAR OF MEETINGS

### State

May 16-19—Third Atlanta Postgraduate Course in the "Treatment of Trauma and Children's Orthopedic Surgery" sponsored by the Committee on Injuries of the American Academy of Orthopedic Surgeons, Riviera Motel, Atlanta.

May 18-20—A Postgraduate Course, "Modern Physical Diagnosis of the Cardiovascular System," presented by the Department of Medicine, Emory University School of Medicine, Grady Hospital Auditorium, Atlanta.

May 19-21—Symposium on Psychiatry and Neurology: A Practical Approach, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla.

June 5-6—Sixth Annual Postgraduate Seminar, "Dental Radiology in the Space Age," Medical College of Georgia, Augusta.

June 9-11—The Great Smoky Mountains Pediatric Seminar (formerly known as the East Tennessee Pediatric Association), Gatlinburg, Tenn.

July 15-16—Twentieth Annual Rocky Mountain Cancer Conference, Brown Palace Hotel, Denver, Colo.

### Regional

June 30-July 2—Symposium on Clinical Aspects of Renal Disease-Ischemic Heart Disease and Cardiac Diagnosis (Sponsored by Tidewater Heart Association, Council on Clinical Cardiology, American Heart Association), Cavalier Hotel, Virginia Beach, Va.

### National

May 23-25—Annual Meeting of the American Thoracic Society, Medical Section of the National Tuberculosis Association, San Francisco, Calif.

May 30-June 1—American Ophthalmological Society (M), The Greenbrier, White Sulphur Springs, West Va.

June 2-4—American Gynecological Society, The Homestead, Hot Springs, Va.

June 26-30—American Medical Association Annual Convention, Chicago.



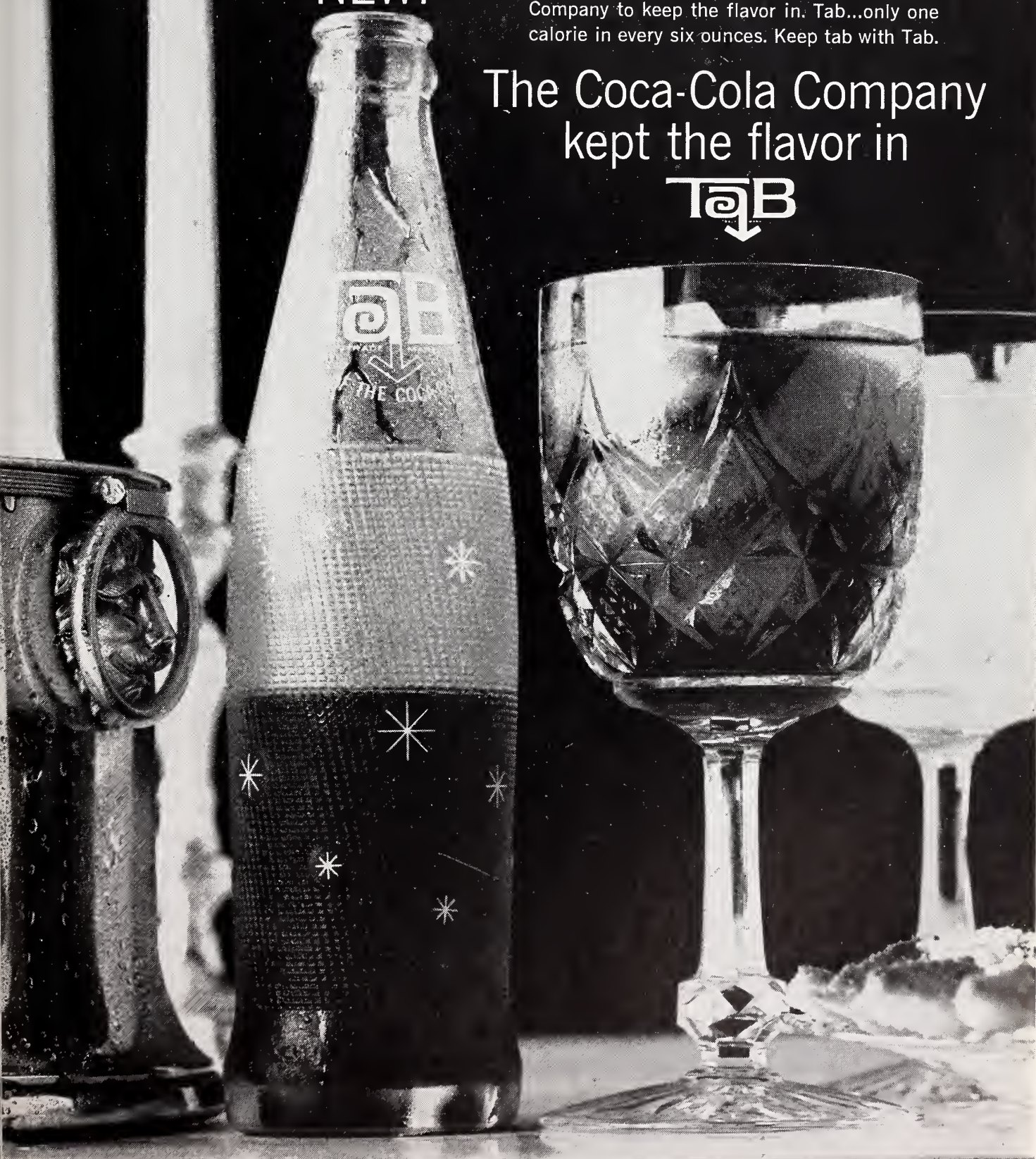
How can just 1 calorie  
taste so good?

An elegant evening . . . candlelight, crystal,  
dinner for two. And the elegant complement  
...new one-calorie drink. The difference in Tab  
is flavor. You see, anyone can take the calories  
out of a soft drink. But it took The Coca-Cola  
Company to keep the flavor in. Tab...only one  
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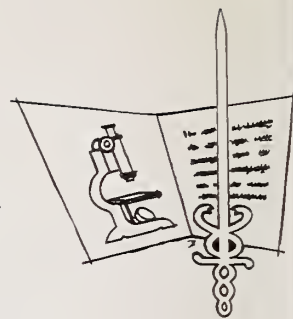
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## CANCER OF THE MOUTH

Charles A. Waldron, D.D.S., *Atlanta*

**C**ANCER OF THE MOUTH comprises an appreciable segment of the total cancer problem. Oral cancer is relatively more common in the Southeastern United States than in other regions and a higher percentage of these tumors occurs in women.

Epidermoid (squamous-cell) carcinomas comprise well over 90% of all oral cancers, and from a public health standpoint, this one neoplasm is the oral cancer problem. The natural history of this tumor offers considerable hope for better control of this disease. This is a "surface" cancer presenting mucosal alterations which should permit early detection on inspection and palpation of the oral mucosa. Unfortunately, however, the experience of our large hospitals and tumor centers shows that too many patients are not seen until the disease is far advanced.

### Slow Clinical Evolution

Oral carcinomas tend to have a relatively slow clinical evolution and probably many of them have a relatively long in-situ stage. Recognition of this disease in its early, asymptomatic and often innocuous-appearing stage offers the greatest hope for increasing the survival rate. Oral carcinoma is frequently preceded by certain mucosal alterations, particularly leukoplakia.

The possible contributing etiologic factors in oral carcinoma have received much attention. There is considerable evidence, however, to link oral carcinoma with poor oral hygiene, heavy use of tobacco and alcohol and other forms of chronic oral irritation. The relationship of tobacco, in the form of snuff, to mouth cancer is particularly interesting. The widespread use of snuff by women in the Southeast has been associated with the increased frequency of mouth cancer in women in our region. These cancers often develop at the site where the snuff is held and are often preceded by and appear to rise in areas of leukoplakia.

Recently there has been considerable interest in the use of exfoliative cytology (pap smear) for the detection of mouth cancer. This technique has proved to be of great value as a diagnostic aid and has demonstrated its value in a number of studies. It should be emphasized that the "pap" smear is only one of several diagnostic techniques, and it is not indicated in all instances. It is most certainly not a substitute for the biopsy. Both the family dentist and family physician have an important role in the detection of early, asymptomatic oral cancer. Since early oral cancer is seldom symptomatic, the necessity for a thorough and careful oral examination is obvious. Particular attention should be given to the lateral borders of the tongue and the floor of the mouth. These areas are the sites of origin of about 50% of intra-oral carcinomas and small lesions in these areas are easily missed by casual inspection.

Exfoliative cytology has proved particularly valuable in the flat, erythematous mucosal lesion which often appears so clinically harmless to the clinician that a biopsy is not recommended. Exfoliative cytology has also been of great value in the diagnosis of certain non-neoplastic mucosal diseases such as pemphigus and certain virus infections.

### To Utilize

The Dental Health Branch of the Georgia Department of Public Health is encouraging dentists in Georgia to utilize this important method. Materials and suppliers are available to dentists from the Dental Health Branch, and a series of lectures for dentists participating in the program have been presented over the state. These will be repeated again this year.

*Emory University School of Dentistry*

Approved by the Professional Education Committee, Georgia Division, ACS.





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### Therapeutic Effects

Up to 75% of patients obtain major relief of arthritic symptoms, as reported by numerous clinicians. In addition, the problem of gastric upset—a major problem with certain other oral antiarthritic agents—is minimized by the presence of antacids and an antispasmodic in the formulation.

Improvement is generally seen within 3 to 4 days, and trial therapy need not be continued beyond a week. Relief of pain is followed quickly by resolution of inflammation and improved joint function. Relief of symptoms is often accompanied by increased appetite, gain in weight and an improved sense of well-being.

The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Cyclo-oxygenase or steroid therapy can usually be discontinued or, in some instances, eliminated.

### Contraindications

Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile or when other potent chemotherapeutic agents are given concur-

## In rheumatoid arthritis—effective therapy with minimal chance of G-I upset

rently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

### Precautions

Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

### Warning

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

### Adverse Reactions

The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may

occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

### Average Dosage in Rheumatoid Arthritis

**Initial:** 3 to 6 capsules daily in divided dose. It is usually unnecessary to exceed 4 capsules daily. A trial period of 1 week is adequate to determine response; in the absence of favorable response, discontinue.

**Maintenance:** An effective level is often achieved with 1 to 2 capsules daily; do not exceed 4 daily.

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## CONGESTIVE HEART FAILURE IN INFANCY

Harry R. Foster, Jr., M.D., *Lithonia*

**C**ONGENITAL HEART DISEASE is the principal cause of heart failure in the first few months of life. In early infancy the respiratory distress syndrome is also a common cause. Failure may also be the result of myocarditis, usually of viral origin, and this may be particularly difficult to recognize, since frequently there is no murmur. Arrhythmias, especially paroxysmal atrial tachycardia, can produce failure. Severe anemia, pneumonia, or sepsis rarely cause failure in the absence of heart disease, but on occasion, primary pulmonary disease is almost indistinguishable from heart failure.

### Principal Manifestations

The principal manifestations of failure are a rapid and usually weak pulse, rapid or labored respirations, hepatomegaly, and a gallop rhythm. Rales and edema are later signs. Tachycardia can be said to be present only with due regard to the age and physical and emotional status of the infant. This also applies to tachypnea and a consistent increase in rate is essential. A prominent feature, as in the adult, is dyspnea on exertion. The only work performed by infants is feeding; therefore, a feeding problem is a constant finding. The usual pattern is for the infant to take only a small amount of his formula, tire and go to sleep only to awaken shortly, again hungry and anxious to eat. On physical examination an enlarged liver is the most constant finding. This is a most useful sign not only for diagnosis but also for assessment of therapeutic effectiveness as liver size corresponds closely to the degree of failure. Splenomegaly is also seen, again on a congestive basis, but is a less common finding. Edema is usually present in failure in infancy, as is demonstrated by considerable weight loss after successful therapy. However, only rarely is this clinically apparent and when seen tends to involve eyelids, face, and scrotum more often than extremities. Rales are uncommon except in extreme failure. When pulmonary findings seem out of pro-

portion to systemic findings, infection should be suspected.

Digitalis is the mainstay in treatment of failure. The most versatile form is digoxin and, indeed, it is the only form usually required. Its particular drawback is that it is not completely absorbed by the gastrointestinal tract. Therefore, parenteral dosage should be only 50% to 75% of the oral dose. A reasonable oral dose in infants for initial digitalization is .035 mgm/lb. body weight. One half this dose may be given initially, one fourth in six hours, and the remaining one fourth in eight to twelve hours. If clinical evidence of digitalis effect is not apparent, another one fourth of the calculated dose may be repeated, after careful observation, every six to eight hours until such effect or toxicity is evident. Maintenance is usually one-tenth of the required digitalizing dose given twice daily. The EKG is useful in detecting digitalis toxicity but of little value in determining therapeutic digitalization. A low salt diet is also useful and in infancy consists of a milk of decreased sodium content such as SMA 26 or Lonolac. Cereal and fruits and vegetables may be started in the usual fashion. One should scrupulously avoid anemia. Mercurial diuretics in a dose of 0.1 to 0.25 cc. may be given as required. A suspension of chlorothiazide containing 250 mgm tsp. is available and quite useful for long-term diuresis. The usual dose is 10 mgm/lb/day. In critically ill infants, particularly those with large left-to-right shunts, an intravenous infusion of 0.3 micrograms of diluted epinephrine per pound of body weight given every minute may occasionally prove life-sustaining awaiting definitive therapy.

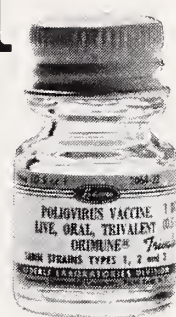
Finally, one must not forget that many lesions are now amenable to either definitive or palliative surgery and open heart procedures may now be performed on infants weighing less than ten pounds.

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*Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.*



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# ABSTRACTS BY GEORGIA AUTHORS



Hagler, Wm. S., M.D., Dept. of Ophthalmology, Emory Univ. School of Medicine, Atlanta, Ga., "Retinal Dialysis as the Cause of a Special Type of Retinal Detachment," *Southern Medical Journal* 58:1475-1482 (December)1965.

The author reviewed 668 patients with retinal detachment and found that 75 or 11% of these were due to a retinal dialysis. In 81% of this series the dialysis occurred in the lower temporal quadrant. This disorder characteristically affects young adults and was found to be the most common cause of detachment in patients under age 25. A detachment due to a dialysis exhibits definite clinical characteristics which were stressed and summarized. They are frequently overlooked unless a thorough fundus examination with complete cycloplegia is performed since they produce minimal symptoms. The use of indirect ophthalmoscopy and scleral depression was considered to be the best means of detecting a peripheral dialysis.

The absence of vitreous liquefaction and the attachment of the vitreous base to the posterior edge of the retinal tear was felt to explain many of the distinctive clinical features of this disorder. There is speculation as to the importance of preexisting trauma but at present the exact etiology of these tears cannot be determined.

The great majority of patients in this series was operated by some type of scleral buckling procedure with a silicone implant. Surgical reattachment was obtained in 97%.

Perdue, Garland D., M.D.; and Lowry, Kermit, M.D., Dept. of Surgery, Emory Univ. School of Medicine, Atlanta, Ga., "Surgical Revascularization After Acute Thrombosis of Carotid Artery," *The American Surgeon* 31:790-792(December)1965.

Sixteen patients with acute stroke and complete occlusion of the cervical carotid artery were subjected to attempted thromboendarterectomy and extraction of the thrombus. Revascularization was successful in 12, six of whom made a dramatic recovery and two of whom recovered more slowly. Four patients died of postoperative hemorrhage into the area of cerebral softening.

While dramatic improvement is sometimes obtained, the hazard of hemorrhage into the infarction resulting in death appears to be considerable.

Durham, Bon M., M.D., Box 1409, Americus, Georgia 31709, "Leptospirosis (Pomona Fever)," *Southern Medical Journal* 59:272 (March)66

A case of Leptospirosis which occurred in a Southwest Georgia dairyman is reported. He was ill about two weeks with rather vague abdominal

symptoms and had fever which never went over 101.4. He had two loose stools at the onset, some nausea, and vomiting, but few other definite symptoms except malaise. He was treated empirically with penicillin, tetracycline, and chloramphenicol and made a complete recovery. At the time of his illness two of his cows had aborted and were found to be positive for Leptospiro, Pomona. It is felt that this condition probably exists more often than the reported incidence and should be considered in cases of fever of undetermined origin. The point of entry in this case probably was contamination through a break in the skin from cow urine, an occupational hazard in a dairyman. Diagnosis in this case was confirmed at the regional state and Communicable Disease Center Laboratories.

Achord, James L., M.D., Dept. of Medicine, Emory University School of Medicine, Atlanta, Georgia, "Pancreatic Replacement Therapy: Its Effect Upon Malabsorption Induced by Neomycin," *Southern Medical Journal* 59:268-272(March)66

Three patients with proven pancreatic insufficiency and one patient with no disease were given neomycin and neomycin plus pancreatic replacement therapy. No influence could be demonstrated of exogenous pancreatic enzymes on neomycin-induced malabsorption of xylose, changes in fecal sodium, potassium and nitrogen, excretion or lowering of serum cholesterol and carotene. In two patients exogenous pancreatic enzymes lowered the amount of fat excreted compared to periods when neomycin alone was given.

The findings in this study are compatible with, but by no means prove, a "poisoning" effect of neomycin on the gut's epithelial cells which is related to both dose and duration of exposure and may be mediated through interference in cholesterol synthesis by crypt cells. The individual variability of the patient's response as regards both rapidity of changes and ability to recover make it desirable to study larger groups under controlled conditions.

Sprawls, Perry, Jr., M.S.; Miller, Wm. B., Jr., B.S., and Logan, Wm. D., Jr., M.D., Dept. of Radiology, Emory University School of Medicine, Atlanta, Georgia, "A Device for Testing Implantable Pacemakers," *The Annals of Thoracic Surgery* 2:99-101(January)66

The failure of an implanted cardiac pacemaker may be due to a fault in either the pacemaker unit or the leads and electrode-to-myocardium connections. A device has been developed for use in the operating room to aid in location of the site of failure. It consists of a simple electronic circuit used in conjunction with a battery powered oscilloscope.

The device can be used to: 1. Determine the output voltage of the implanted pacemaker; 2. temporarily turn off the implanted pacemaker; 3. pace the patient; 4. determine the effective resistance of each electrode and lead; 5. determine the pacing threshold for each electrode.

Bryant, Milton F., M.D.; Bloom, Walter L., M.D., and Brewer, Spencer S., M.D., Ferst Research Laboratory, Piedmont Hospital, Atlanta, Georgia, "Use of Dextran in Thrombophlebitis, Experimental and Clinical Studies," *The American Surgeon* 32:13-16(January)66

The need for a more effective method of preventing and treating thromboembolic disease is recognized by all physicians. Despite many recent advances in the treatment of vascular diseases, autopsy studies reveal an alarming incidence of death caused by pulmonary embolism.

In 1960, new fibrinolytic agents were used for treatment of intravascular clot formation. After evaluation of available fibrinolytic preparations in the experimental laboratory, we concluded that further study of these preparations was necessary before they could be recommended for clinical use. At the same time a new method for preventing post-operative thrombosis in small arteries subjected to standardized mechanical trauma was developed at the Ferst Research Laboratory of the Piedmont Hospital. The effectiveness of clinical dextran in retarding arterial thrombosis suggested that this agent might be of value in preventing and treating thromboembolism. Subsequently, the use of dextran for preventing and treating venous thrombosis has been studied in the laboratory and in selected clinical situations.

Experimental and clinical studies suggest that thromboembolism may be prevented and successfully treated with clinical dextran. It is to be emphasized that dextran, like all drugs, does not act in an absolute, all or none, fashion and one should not expect this substance to be 100% effective in every case.

Hudson, James B., M.D. and Dennis, Allen, Jr., M.D., Dept. of Medicine, Medical College of Georgia, Augusta, Georgia, "Transverse White Lines in the Fingernails After Acute and Chronic Renal Failure," *Archives of Internal Medicine* 117:276-279(February) 66

White transverse lines affecting the fingernails after a varied group of exogenous poisonings and systemic illnesses are well known and were first described by Reil in 1792. It is generally felt that they arise from a non-specific effect on nail growth and reflect the acuteness and seriousness of



the underlying illness. Six patients are reported in whom these transverse white lines followed renal failure. In five cases renal failure was acute and followed trauma in two instances, obstetrical accidents in two and mercuric cyanide poisoning in one. One patient had chronic renal failure which had reached a terminal stage and the nail markings were seen when recovery followed chronic hemodialysis. The nail markings were one or two millimeters wide, completely traversed the nail and had a color similar to that of the lunula. They were first noticed between 78 and 93 days after the onset of severe renal failure and moved toward the free margin at a rate consistent with normal nail growth. Although there were no qualitative differences in the transverse markings which could be correlated with the type of renal failure, they did appear to be most prominent in patients whose renal disease had been most severe. Since less seriously ill patients with azotemia do not commonly develop these findings it is concluded that these transverse markings are evidence of changes in nail growth reflecting the precarious clinical situation to which these patients had been brought by renal failure in concert with its complications and causes.

**Nelson, George H., Ph.D., M.D.; Zuspan, Frederick P., M.D., and Mulligan, Lewis T., M.S., Depts. of Ob-Gyn and Biochemistry, Medical College of Georgia, Augusta, Georgia, "Defects of Lipid Metabolism in Toxemia of Pregnancy," American Journal of Obstetrics and Gynecology 94:310-315(February)66**

Phospholipid, total and free cholesterol, triglyceride, and nonesterified fatty acids were determined in maternal serum, fetal serum, and placental tissue obtained at delivery. Total lipid and water contents were also determined on the placentas. Normal pregnant patients (12) were compared to toxemic patients (10). The toxemic group consisted of four eclamptic and six severe preeclamptic patients. A significant difference was found in the triglyceride content of the placenta which is elevated in toxemia. Correlation coefficients were calculated between each lipid fraction in maternal serum and the corresponding measurement in the fetal serum to see if high and low values in maternal serum corresponded to high and low values in fetal serum. No significant correlations were obtained. This suggests that simple diffusion of lipid fractions from maternal blood to fetal blood does not occur. A positive relationship between serum cholesterol and phospholipid has been noted repeatedly in the literature in nonpregnant adults. Correlation coefficients were calculated in this study between both free and total cholesterol versus phospholipid in serum and placentas of the control and toxemic groups to test such a hypothesis in pregnant patients. Significant positive correlations between the free cholesterol content and the phospholipid content were obtained in maternal serum, fetal serum and placental tissue in control patients. In the toxemic patients only in maternal serum was a significant correlation ob-

tained. Significant positive correlations between the total cholesterol content and the phospholipid content were obtained in maternal serum and fetal serum in control patients. Toxemic patients showed a significant correlation only in maternal serum. In normal pregnancy certain factors are responsible for the positive relationship between cholesterol and phospholipid levels in fetal serum and placentas. In toxemia of pregnancy these factors are altered.

**Logan, William D., Jr., M.D.; Abbott, Osler A., M.D.; and Hatcher, Charles R., Jr., M.D., Emory University Clinic, Atlanta, Georgia, "Kartagene's Triad," Disease of the Chest 48:613-616(December)65**

In 1933, Kartagene reported an unusual triad: situs inversus, bronchiectasis, and sinusitis. This is a report of 15 cases including discussion of familial relationship, surgery, and general considerations.

Seven of the 15 cases occurred in four families with multiple siblings having one, two, or all three components of this triad. Although no cases of the complete triad have been reported in successive generations, the occurrence of significant sinusitis and bronchitis in the parents of one family is interesting. There was one set of identical twins.

Bronchiectasis occurs more frequently in patients with situs inversus. This is reported 12%-25% as opposed to 0.3%-0.5% in general population. The etiology and relationship of bronchiectasis in situs inversus is probably congenital, but it is difficult to determine the factor involved.

Management of these cases did not vary from the usual treatment of suppurative tracheobronchial and paranasal difficulties. Pulmonary resection was done in five of these cases.

**Anabtawi, Isam N., M.D.; Womack, Charles E., B.S. and Ellison, Robert G., M.D., Dept. of Thoracic Surgery, Medical College of Georgia, Augusta, Georgia, "Thoracic Duct Lymph Flow During Pulsatile and Nonpulsatile Extracorporeal Circulation," The Annals of Thoracic Surgery 2:38-43(January) 66**

The cannulated thoracic-duct lymph was measured in each of 20 dogs under variable periods of high flow, low flow, pulsatile and nonpulsatile perfusions. Four to sixfold increase in lymph flow occurred at the onset of extracorporeal circulation, reaching its peak in 30 to 40 minutes with a gradual return to near preperfusion levels. This increase was not affected by the rate of perfusion or pulsation. Despite improvement in venous return during pulsatile flow, lymph flow was not altered. Lymph flow was directly proportional to the mean arterial pressure regardless of pulsations. However, this relationship was only qualitative. These studies indicate a limited capacity of the major lymphatic duct system to carry lymph, hence favoring retention of fluids and proteins in the interstitial spaces during extracorporeal circulation. It emphasizes the desirability of low priming volumes to minimize the lymphagogue effect of added plasma and the need to curtail fluid intake in the immediate postoperative period until hemostasis

is reestablished. Adequate perfusion pressures are desirable, but pulsations are not essential for the return of lymph via the thoracic duct.

**Talledo, Eudardo, M.D. and Zuspan, Frederick P., M.D., Dept. of Ob-Gyn, Medical College of Georgia, Augusta, Georgia, "Fetal Electrocardiography: A Clinical Appraisal," Clinical Medicine, 73:35-37(January)66**

A brief review of the electronic equipment, lead system and the fetal heart signal is given to help to understand the present development of fetal electrocardiography. A critique of the clinical applications is offered with special emphasis in early detection of fetal life and evaluation of bradycardia during labor. Its use in the management of other clinical conditions such as threatened abortion, differential diagnosis of pelvic masses and hydatidiform mole seems promising.

**Yeh, Thomas J., M.D.; Toyhara, Hiroshi, M.D.; Ellison, Louis T., M.D.; Parker, James L., M.D. and Ellison, Robert G., M.D., Medical College of Georgia, Augusta, Georgia, "Pulmonary Function in Dogs After Lung Homotransplantation," Annals of Thoracic Surgery 2:195-203(March)66**

Experiences with canine lung homotransplants and immunosuppression using methotrexate or Imuran are presented. Although either drug can prolong host survival considerably, neither is effective in preventing rejection of the graft and eventual loss of function. A few exceptional cases will survive for years and function may be demonstrable at three months. Imuran may be slightly superior from the survival standpoint, but for preservation of pulmonary function it is comparable to methotrexate. The function of the graft can be reliably predicted from the chest roentgenogram. The rejection is characterized physiologically by increased venous admixture with resultant hypoxia and loss of ventilation and oxygen uptake by the affected lung, and by loss of alveolar surfactant. The pneumonitis seen in the opposite lung may be due to a host response to the graft rather than the immunosuppressive therapy.

**Smith, Richard A., M.D. and Smith, Wm. A., M.D., 384 Peachtree St., N.E., Atlanta, Georgia, "Loss of Memory as a Sign of Focal Temporal Lobe Disorder," Journal of Neurosurgery 24:91-95(January)66**

Almost total loss of recent memory was observed in a patient as the initial and outstanding sign of a tumor of the medial left temporal lobe, which destroyed the posterior left hippocampus. In a patient whose intellect seems otherwise well preserved, this is believed to be an important sign of focal temporal lobe disorder. Loss of recent memory has been reported from vascular, traumatic, and experimental lesions of the temporal lobe, but has not been previously described as an isolated sign of neoplasm in this area in patients who are alert and not aphasic or otherwise mentally disturbed. A similar syndrome has been reported from tumors involving the floor of the third ventricle. These facts correlate well with current theories of memory mechanisms.



## ABSTRACTS / Continued

Smith, Edgar B., Maj. MC, USA and Gellerman, Gerald L., Capt. MC, USAR, Dermatology Service and Pediatric Service, Martin Army Hospital, Ft. Benning, Georgia, "Tinea Versicolor in Infancy," *Archives of Dermatology* 93:362-366(March)66

In temperate climates tinea versicolor is generally considered a disease of young adults. It is, however, seen occasionally in children and in aged people. The frequency of tinea versicolor in children is much higher in the tropics. When infants are involved, the lesions tend to occur on the face and diaper area. The case of a Caucasian male infant who developed depigmented scaly macules of tinea versicolor on the forehead and neck at the age of eight weeks is reported. A diagnosis of tinea versicolor was made at age three and one half months and the infant was treated with daily washing with selenium sulfide shampoo (Selsun) with clearing of the skin lesions. It is believed that this patient is the youngest with tinea versicolor to be described in a temperate climate.

Stone, H. Harlan, M.D., Dept. of Surgery, Emory University School of Medicine, Atlanta, Georgia, "Review of *Pseudomonas* Sepsis in Thermal Burns: Verdoglobulin Determination and Gentamicin Therapy," *Annals of Surgery* 163:297-305(February)66

During the past 18 months, 168 major burns in children have been hospitalized. The mortality rate was 2.4%, and there was only one septic death. This represents a dramatic reduction in mortality rate from the 16.1% of the preceding 18 month period.

Certain principles have evolved from both this clinical experience and some related laboratory experimentation. Specifically, these are:

1. Prophylactic antibiotics continued beyond the first 24 hours favor an earlier and more severe *Pseudomonas* sepsis.
2. Gram-negative (especially *Pseudomonas*) sepsis usually follows within ten days the institution of specific anti-Staphylococcal drugs.
3. For intelligent management of the individual case, frequent bacteriological surveys are a necessity.
4. The Green Urine Syndrome is a manifestation of toxemia due to absorption from the wound of toxins

which reside in the slime layer of *Pseudomonas*.

5. *Pseudomonas* exotoxins are major lethal factors, and verdoglobinuria is merely a reflection of their activity.
6. Reduction of toxin absorption can be achieved by topical application of an effective antibiotic, preferably gentamicin sulfate.
7. During toxemia, appropriate systemic antibiotics is also necessary to prevent or eradicate the associated septicemia.
8. Early wound closure is best accomplished by use of meshed autografts, with or without supplemental homografts.

Lucas, James B., M.D.; Thayer, James D., Ph.D.; Utley, Philip M., M.D.; Billings, Terrence E., M.D., and Hackney, James E., M.D., Venereal Disease Branch, CDC, Atlanta, Georgia, "Treatment of Gonorrhea in Males With Cephaloridine," *JAMA* 195:919-921(March 14)66

Eighty-four male patients with culturally proven anterior gonococcal urethritis were treated with a single intramuscular 2 gm injection of cephaloridine. A total of 43 patients completed follow-up and five of these were culturally positive. On epidemiologic and laboratory evidence, three cases were considered reinfections and not therapy failures.

Data are presented comparing the *in vitro* sensitivities of 67 strains of *N. gonorrhoeae* isolated in the study against penicillin G, cephalothin, and cephaloridine. Despite greater *in vitro* sensitivity to cephalothin, cephaloridine was found to be significantly superior clinically in males with gonorrhea.

The drug was well tolerated by all patients and no toxic or allergic manifestations of any kind were noted.

Kuck, John F. R., Jr., Ph.D., Dept. of Ophthalmology, Emory University School of Medicine, Atlanta, Georgia, "Sorbitol Pathway Metabolites in the Diabetic Rabbit Lens," *Investigative Ophthalmology* 5:65-74(February)66

The lens of the alloxan diabetic rabbit with a plasma sugar value of 502 mg% has 141 mg% glucose, 94 mg% fructose, and 81 mg% sorbitol. This accumulation of metabolites is accompanied by the occurrence of peripheral vacuoles. In rats with a comparable blood sugar level (667 mg%) such vacuoles also occur but the accumula-

tion of metabolites, particularly sorbitol, is much higher (1,293 mg% total). A consideration of the many factors involved: concentrations of substrates and co-factors, enzyme activities, and permeability differences, suggests that the rabbit lens may be more sensitive to diabetes than the rat lens because of a relative deficiency of DPN and especially TPNH. In the normal rabbit lens the concentrations of these co-factors are not rate-limiting but in diabetes the enhancement of the sorbitol pathway in response to the elevated glucose level leads to a real deficiency of DPN and TPNH and a reversal of the normal ratios of TPNH/TPN and DPN/DPNH. These changes are a severe metabolic embarrassment to the lens, which develop vacuoles and eventually cataract.

Ridley, John H., M.D., 1211 W. Peachtree St., N.E., Atlanta, Georgia 30309, "Primary Adenocarcinoma in Implant of Endometriosis," *Obstetrics and Gynecology* 27:261-267(February)66

The true incidents of adenocarcinoma arising in ectopic endometrium is difficult to determine. Undoubtedly it is more frequent than is expected; to date the literature contains reports of 17 cases of proven primary adenocarcinoma arising in the implants of endometriosis—"proven" indicating that the exact criteria for diagnosis set forth by Sampson in 1925, have been met.

Two more cases herein reported raised this total number to 19 cases. Another criterion is suggested to the author for academic interest.

It is believed that the true incident of endometriotic adenocarcinoma is actually greater than one would suppose, considering the academic limitations for the diagnosis. The term "endometrioid" adenocarcinoma has justifiably found its way into the nomenclature. The practical value of this is shown by the fact that, in light of more recent refinements of treatment, including chemotherapy and supervoltage irradiation, the actual prognosis of the case of endometriotic adenocarcinoma is somewhat better, even though slight, as compared with the somewhat similar papillary serous cystadenocarcinoma, with which it might be confused.

Careful observation and interpretation of gross findings by the operating gynecologist and microscopic appearance by the pathologist would no doubt result in a more frequent recognition of this condition.

## NOTE ERRATUM

In the scientific article, "Placentography: A Comparison Between X-Ray Amniography and Sac Distention Methods," that appeared in the April, 1966 issue of the *Journal of the Medical Association of Georgia*, there was an error in the placement of one of the illustrations. Figure 2(b) on page 133, top right hand corner should be turned 45 degrees to the right. The position the illustration is now in puts the placenta at the top when it should be shown at a right angle.



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## DEATHS

**Ellsworth F. Cale**, Chairman of the Pediatrics Department at Piedmont Hospital, Atlanta, died March 20, 1966, in a private hospital. He was 48.

Dr. Cale had served as a staff member of both the Henrietta Egleston and Grady Memorial hospitals.

A native of Green Spring, West Virginia, he was a graduate of the University of West Virginia and Duke University and the Medical College of Virginia.

Dr. Cale was a member of St. Luke's Episcopal Church and the Fulton County, Georgia and American Medical Associations.

Survivors include his wife, the former Ruth Berry; a daughter, Miss Beverly Cale and a son, Bennett Cale, all of Atlanta; his mother, Mrs. Mark A. Boone, and a brother, Jack E. Cale, both of Forest Hill, West Virginia, and a sister, Mrs. Homer L. Henrioud, East Point.

**Carmen Cornejo** of East Point died March 20, 1966.

Dr. Cornejo, 39, studied medicine in Havana, Cuba, and came to the United States in 1953. She was born in San Juan, Puerto Rico, and was a member of the staff of South Fulton Hospital.

Survivors include her parents, Mr. and Mrs. Ignacio Guigon, Atlanta.

**Allen William Coward**, 50, of Savannah died March 25, 1966, at his home.

He was a native of Savannah and a member of St. John's Church. He was a graduate of Savannah High School, the University of Georgia and the Georgia Medical College in Augusta.

He was a former president of the staff at St. Joseph's Hospital and had served as physician of the Savannah Division of the University of Georgia at Hunter Air Force Base. He was a member of the Georgia Medical Society and the Atlantic Coast Line Surgeon's Association.

Dr. Coward had maintained offices at 17 E. Jones St. since his separation from the Army Air Force in 1946. He served as a captain and a surgeon during World War II and was in the North African campaign. Before entering the service he served his internship at City Hospital in Macon.

Surviving are his wife, Mrs. Ruth Hardeman Coward; two sons, Allen W. Coward, Jr. and James Hardeman Coward; his mother, Mrs. E. S. Coward; two brothers, Milton Coward and Walter Coward; and two sisters, Mrs. Alphen Dowell and Mrs. Sidney Baughn.

**William Howard Perkinson**, Cobb County physician for over 40 years, died March 6, 1966, in a private hospital. He was 87.

Dr. Perkinson, a native of Cherokee County, was a graduate of the old Atlanta College of Physicians, now Emory's Medical School. He was a member of the Cobb, Georgia and American Medical Associations and the First Baptist Church in Marietta.

He was also a director of the First National Bank of Marietta and was a member of the Masons and the Rotary Club.

Survivors include his wife; a daughter, Mrs. Middleton Fitz-Simons, Atlanta, and a sister, Mrs. J. E. Stephens, Marietta.

**T. J. VanSant, Sr.**, age 89, of Woodstock, died March 31, 1966. Surviving are his wife, Mrs. Birdie Lovinggood VanSant, Woodstock; one daughter, Mrs. H. L. Skeen, Ballwin, Missouri; three sons, W. A. VanSant, Jasper; Dr. J. P. VanSant, Jasper; Dr. T. J. VanSant, Jr., Marietta; 12 grandchildren and one great-granddaughter; two sisters, Mrs. Vertis Erwin, Winter Haven, Florida; Mrs. Jessie Milner, Gadsden, Alabama; a brother, Dr. J. P. VanSant, Dewey, Oklahoma; and several nieces and nephews.

## COUNTY MEDICAL SOCIETIES

The President-Elect of the American Academy of General Practice, Carroll L. Witten, M.D. of Louisville, Kentucky, spoke to the **Richmond County Medical Society** meeting March 22, 1966. Dr. Witten, a private practitioner, is also a member of the University of Louisville School of Medicine faculty. In 1959 he was selected Doctor of the Year in Kentucky.

**Seventh District Medical Society** was the guest of the **Floyd County Medical Society** on April 6, 1966, at Rome. Four scientific papers were presented on the Program: "Office Management of the Depressed Patient," James S. Cheatham, M.D., Diplomate, American Board of Psychiatry, Chattanooga, Tenn.; "Psychosomatic Medicine—Case Presentation," E. James McCranie, M.D., Chief, Department of Psychiatry, Medical College of Georgia, Augusta; "Follow-up and Supportive Care by the Family Physician for Patients Returned From Mental Hospital," Lawson Bolling, M.D., Clinical Director, Georgia Mental Health Institute, Atlanta; and "A Comprehensive Mental Health Program for Georgia," Addison Duval, M.D., Director, Division of Mental Health, Georgia Department of Public Health, Atlanta.

## PERSONALS

### First District

**Elizabeth Whitner** of Atlanta has been named Medical Director for the mental retardation clinic which will be set up at the Chatham County Health Dept.. **W. D. Lundquist**, health commissioner, has announced.

Dr. Whitner, a pediatrician, has been working as a consultant with the State Health Dept. in Atlanta. With the department she has worked in the School for the Deaf, the Crippled Children's Services and the School of Education.



## Second District

**Jack G. Standifer**, Blakely, has been cited by the Honorable Maston O'Neal, U. S. House of Representatives, in the February 23, 1966, issue of the *Congressional Record*, for his more than half century of continuous service as a weather observer for the U. S. Weather Bureau. Dr. Standifer took charge as local observer for the U. S. Weather Bureau August 14, 1914.

Bainbridge Memorial Hospital was the scene of a display of warm admiration March 5, 1966, when several hundred friends of **Gordon Chason**, attended a reception to congratulate Dr. Chason on his 90th birthday. The reception was given in his honor by the doctors and their wives of Bainbridge.

"The History of Making a Doctor," was the title of a talk given by **Carl Pittman, Jr.**, Tifton, at the February meeting of the Allied Medical Careers Club.

## Fifth District

Georgia physician, **A. H. Letton**, Atlanta, was named to head the National Public Education Committee for the American Cancer Society. Dr. Letton, a member of the Georgia Division, American Cancer Society Board of Directors, was announced as the new Public Education Chairman at the Society's National Board Meeting in New York in January.

The Editor of the *American Journal of Clinical Hypnosis*, Milton H. Erickson of Phoenix, Arizona, an authority on clinical hypnosis, was the featured speaker at the Georgia Society of Clinical Hypnosis Annual Postgraduate Seminar held in March at Atlanta. Also on the program was **Sheldon B. Cohen**, Atlanta psychiatrist and past president of the Georgia Society.

**Winston E. Burdine**, Atlanta psychiatrist, has announced the opening of the new Northside Manor Hospital on April 9, 1966. This new non-profit 35-bed psychiatric hospital is located at 811 Juniper St., N.E., Atlanta, Georgia.

**John R. Lewis, Jr.**, of Louisville and Atlanta, visited Mexico City, Mexico, in March. Dr. Lewis attended a meeting of the Seminar on Cosmetic Surgery and was issued a special invitation to attend, join in and lead discussions on problems dealing with cosmetic surgery.

## PARKWOOD HOSPITAL IN ATLANTA, BRAND NEW LONG-TERM PSYCHIATRIC FACILITY OPENED IN MARCH

Parkwood Hospital, a new forty bed, long-term psychiatric treatment center, has been established in Atlanta.

More than 30 psychiatrists can treat patients at Parkwood. Dr. August S. Yochem, Jr. is the acting Medical Director. A trained staff of psychiatric nurses and aides create a favorable milieu for the handling of disturbed patients. In addition, the staff includes a registered occupational therapist who has a large, well-equipped occupational therapy department, and a registered music therapist—both of whom assist in carrying out doctors' orders for diversified disciplines. Additional facilities include x-ray, laboratory, pharmacy, minor

**J. Frank Walker**, Atlanta, has been reappointed a member of the Council on Legislative Activities of the American Medical Association.

**Bruce Logue**, Atlanta, was recently visiting Professor of Medicine at Duke University School of Medicine, Durham, North Carolina.

**Robert M. Fine**, Decatur, spoke on, "Epidemiology of Arthropod Dermatoses and Allergies," on March 1, 1966, in cooperation with the Communicable Disease Center's course on Epidemiology of Vector-Borne Diseases. Dr. Fine also attended the March meeting of the Louisiana Dermatological Society and the New Orleans Graduate Medical Assembly.

On February 23, 1966, **Dr. Sidney Olansky** was guest professor at Washington University in St. Louis. He addressed the house staff and the full time faculty of dermatology regarding dermatological problems as well as venereal disease and also conducted grand rounds on February 24, 1966.

## Sixth District

Joseph G. Molnar, M.D., Detroit, Michigan, nationally syndicated columnist, spoke on, "How to Live Longer and Be Happier," at the third of four public forums held at Macon in March. A panel of local physicians served on the panel with Dr. Molnar. They included **Hugh Sealey**, Moderator; **Thomas Ross**, **Charles Richardson**, and **Earl Lewis**.

## Tenth District

**Corbett Thigpen**, Augusta, was one of the guest speakers at Augusta Preparatory School in March.

**William A. Scoggin**, Augusta, has been named Professor and Chairman of the Department of Obstetrics and Gynecology at the Medical College of Georgia, Augusta.

Dr. Scoggin, now Associate Professor, Department of Obstetrics and Gynecology, Western Reserve University School of Medicine and Director of Obstetrics and Gynecology at Cleveland Metropolitan General Hospital, will assume his new duties in Augusta in May.

Dr. Scoggin received his B.A. degree from the University of Virginia and his M.D. degree from the University of Virginia School of Medicine where he later served as instructor and then assistant professor in the Department of Obstetrics and Gynecology.

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ness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems. Before prescribing, see SK&F product Prescribing Information.

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## SUMMARY OF RECENT MAG COUNCIL AND EXECUTIVE COMMITTEE ACTIONS

(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal.)

### Executive Committee of Council/March 12, 1966

**Appointments**—Dr. Alexander asked for Executive Committee's approval of the following appointments:

(a) *Alcohol Advisory Committee*: Approved submission to Governor the following nominations: Arthur P. Richardson, Atlanta; Lawrence Lee, Savannah; and James Kaufman, Atlanta.

(b) *Georgia Youth Council Advisory Committee*: Approved the following appointments: Allen McDonough, Atlanta; Dixon Lackey, Atlanta; and William Morrison, Atlanta.

**Health Department JMAG Page**—Dr. Alexander stated that the possibility of publishing a State Department of Health page in the *JMAG* each month was not feasible but after discussion, on motion it was voted to inform the State Department of Health that the Publications Committee wishes to make available at any time space in the *JMAG* for pertinent information from the State Board of Health which is of interest to the membership. On further motion it was voted to ask the Editor to make the decision regarding publication of the material when submitted.

**Report on February Board of Health Meeting**—Dr. Brown reported that he had attended the February Board of Health meeting and enumerated the actions of the Board. Received for information.

**Insurance and Economics Board Report**—Deferred for report to Council.

**Carrier Under Part B Medicare Law**—Dr. Alexander reported on a meeting with the John Hancock Company representative on February 18 at which time certain recommendations were made for consideration by John Hancock in which this Association could be of assistance. (A copy of these recommendations is attached to these official minutes.)

There will be another meeting with the John Hancock representative on March 16 to discuss further details of the function of carrier under Part B. Dr. Alexander, Dr. Mauldin and Mr. Krueger will be present and report to Executive Committee in April on the results of the meeting.

**Certificates of Appreciation**—The following were approved for recommendation to Council:

(1) President; (2) First Vice President; (3) Secretary; (4) AMA Delegate Tift; (5) Councilors not re-elected and Vice Councilors to be decided by Executive Committee in April; (6) Thomas W. Goodwin, Chairman, Medical Education Board; (7) Charles H. Richardson, former Chairman, Talmadge Hospital Liaison Committee; (8) Mrs. Louie H. Griffin, Auxiliary President; (9) Thomas N. Lumsden, Chairman, Rural Health Committee; (10) Edgar Woody, Editor *JMAG*; (11) Mrs. Bruce Schaefer, Director, State Department of Family and Children Services; (12) Four physicians in Georgia Legislature: Charles B. Watkins, Ellijay; Frank P. Holder, Jr., Eastman; Carl P. Savage, Sr., Montezuma; and A. Sidney Johnson, Sr., Elberton; (13) J. Lee Walker, formerly of Nahunta, now of Iowa; (14) Arthur P. Richardson, Dean, Emory University School of Medicine; (15) Harry B. O'Rear, President, Medical College of Georgia.

**Headquarters Office Report**—Mr. Krueger reported on:

(a) *AMA 2nd National Conference on Health Education of Public, scheduled for April 14-16, 1966 in Chicago*: The Executive Committee voted not to send a representative to this meeting.

(b) *Office Management Survey*: The Executive Committee voted that a four man committee be appointed to go over the report with the Executive Secretary and make recommendations to Executive Committee. The President, President-Elect, Secretary and Treasurer should comprise this committee. It was suggested that the Councilors be asked to consider appointing a deputy councilor to assist them, as suggested in this report. The Executive Secretary was instructed to implement the items he desires as far as operational procedures in the Headquarters Office.

(c) *AMA Delegates*: AMA has asked for a two and two basis for delegates' elections as MAG has a three to one basis now. On motion it was voted to recommend to Council that AMA Delegate Tift's successor and alternate delegate run for a one year term to equalize the four delegates' terms of office to a two and two basis. It was suggested that the Attorney be asked to give a ruling at Council meeting on

whether an alternate delegate must resign if he desires to run as delegate.

(d) *Councilor Redistricting*: The Fourth and Fifth Districts are now synonymous with the DeKalb County Medical Society and the Fulton County Medical Society. The MAG attorney's opinion is that the President and Secretary of the DeKalb and Fulton County Medical Societies could act as the President and Secretary of the Fourth and Fifth Districts. On a motion it was voted that the Fourth and Fifth Districts should become synonymous with DeKalb and Fulton County Medical Societies with the President and Secretary of each county medical society to act as the President and Secretary of the Fourth and Fifth Districts, with the disposition of dues already collected, when the two districts had functioning district societies, to be prorated according to county society membership.

### OLD BUSINESS—

(a) *Installation of Officers at Annual Session*: Dr. Alexander read a proposed installation of officers procedure which was approved.

(b) *Suggestions about Future MAG Annual Sessions and Officers Conferences*: President Alexander read two letters from Dr. Simone Brocato, Columbus, regarding suggested changes in the Annual Sessions and Officers Conferences. After discussion Dr. Alexander was asked to write Dr. Brocato that the Executive Committee felt that the Officers Leadership Conference should be held immediately after they take office in January; and that the matter about future Annual Sessions would be referred to the Annual Session Board. This action is to be reported to Council.

(c) *U. S. Chamber of Commerce Conferences on Leadership*: Dr. Alexander and Mr. Moffett were asked to attend the local conference to be held March 28, at the Hilton Inn, Atlanta; and that a representative from Fulton County Medical Society should be asked to attend. This matter should be mentioned at the Council meeting if any councilors are interested in attending.

(d) *Florida Medical Association Fraternal Delegates*: To be referred to Council.

(e) *Department of State Regional Foreign Policy Conference*: Dr. Alexander read an invitation from the State Department to attend a conference on April 2 which will be held to examine current international problems and provide opportunity for discussion between leaders and policy making officials. It was voted to ask Fulton County Medical Society to send a representative ad to make a report to the Executive Committee.

(f) *Date and Site of April Executive Committee Meeting*: April 17, 1966, 10:00 a.m., at MAG Headquarters, Atlanta, if enough agenda items to warrant, otherwise a telephone conference will be held.

**Recommendations Made to John Hancock (Carrier for Georgia Under Part B "Medicare" Law P.L. 89-97)**

- (1) That any program of physician information on Part "B" should be conducted by MAG in liaison with the Carrier.
- (2) That, by arrangement with the Carrier, MAG should:
  - (1) process "problem" and appeal claims.
- (3) That, by arrangement with the Carrier, MAG should set up county and state medical review committees.
- (4) That, through arrangement with the Carrier, MAG wishes to co-establish a basis of usual and customary fees as "reasonable."
- (5) That, upon invitation by the Carrier, MAG wishes to participate in the initial and subsequent contract negotiations between the Carrier and the Government in the capacity of "friend-of-the-Carrier."

### COUNCIL/March 12-13, 1966

Chairman Andrews opened the meeting with a statement regarding the discussion of certain items of business at the Council meetings which are confidential and which should be treated as such outside the meetings. He asked that this be kept in mind in the future due to certain recent occurrences.

Dr. Andrews also announced that Dr. Ralph Johnson, of Rome, Councilor of the Seventh District, had a coronary and could not attend the Council meeting. The Secretary was asked to write Dr. Johnson.



## SUMMARY OF MINUTES / Continued

**Lead Salt Poisoning in Illegal Whiskey**—Mr. Robert P. Lane, of the Alcohol and Tobacco Tax Division, U. S. Treasury Dept., and Mr. Bruce Baldwin, of the Alcohol and Tobacco Tax Division, U. S. Treasury Dept., were introduced by Dr. Virgil Williams. Mr. Lane reported on the illegal whiskey situation in Georgia, stating that 90% of the "moonshine" was produced in the South, and 40% in Georgia. Chemical analysis has proven that substances found in the illegal whiskey are poisonous and the medical profession could be of great help in informing the public of these hazards. The Alcohol and Tobacco Tax Division would like an endorsement to the effect that this whiskey is a health hazard and would like to instigate a publicity program to enlighten the public, with participation by the Medical Association of Georgia. Council voted to approve in principle the suggestions made by Mr. Lane and refer the matter to the Public Service Board.

**Report of Treasurer**—Dr. Atwater presented the following:

(a) **Treasurer's Report:** Council voted to accept the Treasurer's Report as presented.

(b) **Subcommittee on Blood Banks Request for Funds:** Mr. Moffett presented for Dr. Menard Ihnen, Chairman of the Blood Banks Subcommittee, a request for the allocation of \$25.00 to continue MAG membership in the American Association of Blood Banks. Dr. Ihnen had not known of this expense when the budgetary requests were made. On motion it was voted to approve the payment of \$25.00 for dues in the AABB with the funds to be taken from the Contingent Fund.

(c) **Auditor's Report:** Dr. Atwater reviewed the Auditor's report for 1965 and this was approved by Council. On motion duly made and seconded (Collins-Brown) it was voted to transfer the excess money as shown in the 1965 audit to the Contingent Fund.

**MAG Pension Plan**—Mr. John Moore, MAG Attorney, after having been requested by the Executive Committee to present a proposal regarding the pension plan, due to the fact that the government had ruled that the Association could not wait until March each year to determine the amount of money to be contributed to the pension plan, and that the Association would have to set aside so much money each year for this purpose, read the attached resolution (see copy attached). After discussion, on motion (McDaniel-Alexander) Council voted that the plan be approved at 8% for 1965, with the money to be paid immediately to the Fulton National Bank as trustees and charged to the Contingent Fund; and that beginning for the year 1966 and afterward, the money be paid quarterly in March, June, September and December; and that the budget for 1966 be amended to show this change. A copy of the First Amendment to the Retirement Plan of the Medical Association of Georgia is also attached.

**Appointments**—Dr. Mauldin stated that a request from the Governor's office, regarding nominations from the sixth and eighth Districts for the State Board of Health because of the expiration of terms of office in these districts, had been complied with and the following names had been submitted:

Sixth District: Beverly W. Forester, Macon; Charles T. Cowart, LaGrange; and Edward A. Prieto, LaGrange.

Eighth District: Robert E. Perry, Brunswick; W. A. Dickson, Nashville; and Van B. Bennett, Valdosta.

It was understood that Dr. Forester had been reappointed and also Dr. Dickson. Received for information.

**Report of Fee Negotiating Committee and Insurance and Economics Board Activities**—Dr. Jennings reported on the activities regarding (a) the Military "Medicare" Contract, which had been extended for ninety (90) days in order for the Fee Negotiating Committee to have time to study the issues further. The ODMC had proposed a negotiation on an interim fee schedule based on the 1964 California Relative Value Schedule. This was received for information. (b) **Blue Shield Prevailing Fee Concept** has been assigned to the Insurance and Economics Board at the December Council meeting for the further investigation of the Prevailing Fee Concept being considered by the Blue Shield. Dr. Jennings' board had investigated this and he made the recommendation that MAG take no action, and suggested that this concept be studied, approved or disapproved on a county society basis. Council voted that the county medical so-

cieties should be acquainted with the prevailing fee concept advocated by the Blue Shield and that the councilors should call this to the attention of their district societies.

**Ad Hoc Committee on Medical Ethics Recommendation on Physician Ownership of Pharmacy Resolution**—Chairman Andrews read the following action of the Medical Ethics Committee:

"It is unethical for a physician to participate in the ownership of a drug store in his medical practice area unless adequate drug store facilities are otherwise unavailable and provided there is no exploitation of the patient."

On motion (Dillinger-Alexander) it was voted to reaffirm the Association's original position and accept the additional recommendation of the Medical Ethics Committee i.e., "provided there is no exploitation of the patient."

**Report of Constitution and Bylaws Board**—Mr. John Moore, MAG Attorney, explained the proposed changes as it affects Councilors. The remainder of this report was deferred for presentation.

**Paramedical Recruitment and Training Program**—Dr. Alexander reported, in the absence of Dr. John Godwin, Chairman of the Paramedical Study Committee, there is a school in DeKalb County, the DeKalb Area Technical School, that is establishing a paramedical training program which the Executive Committee was recommending to Council for approval on the basis (1) that the school have an advisory committee of pathologists; (2) that all prospective students be interviewed and approved by a pathologist before acceptance; (3) that the program be reviewed annually by the advisory committee; and (4) that the course of study be 18 consecutive months. Dr. Alexander recommended that Council approve the establishment of such a training program in the DeKalb Area Technical School. On motion duly made and seconded it was voted to approve this recommendation and to ask the President to appoint an advisory committee composed of two MAG members to supervise the operation of this training program.

**Compliance Requirement P.L. 88-352**—Dr. Alexander reiterated the Council action of December 1965 and read the revision in the resolution submitted by Dr. Christmas, as suggested by the attorney and referred by the Executive Committee to Council for approval:

"*Proposed Resolution, as Revised, of Dr. Joseph Christmas*

### RESOLVED:

1. That MAG issue a statement of policy similar to that adopted by the AMA House of Delegates—that attempts by Federal Agencies to impose conditions and pledges upon the medical profession should be forcefully opposed.

2. That the right of the individual physician to set policy concerning his private practice of medicine be maintained.

3. That MAG support and work through its officers actively for the establishment of a plan whereby the patient pays the physician of his choice and receives a direct reimbursement regardless of which agency administers the Federal fund.

4. That MAG, through its Executive Committee, work with other state associations and the AMA in an effort to preserve the doctor-patient relationship, voluntary service to humanity and independence in the practice of medicine."

Council considered the matter, with Dr. Christmas having spoken of his suggested changes, and it was then recommended that the wording in "3." be changed to read accordingly:

"3. That MAG support and work through its officers actively for the establishment of a plan whereby physicians always have a choice of either (a) the patient paying the physician of his choice and receiving a direct reimbursement from the particular governmental agency; or (b) the patient assigning his benefits to the physician of his choice; and that such choices be available regardless of which governmental agency is administering the program."

On motion (Alexander-Brown) it was voted to approve the resolution with the change in wording in paragraph 3. as noted above.

**Legislative Report**—Dr. Walker read a letter of commendation written by the four physician members of the Georgia House of Representatives about Mr. Moffett and the effective manner in which he worked with them and other members of the Legislature during the time the 1966 General Assembly was in session. He also stated that the annual trip to Washington for the luncheon-meeting with



the Georgia Senators and Representatives is being planned; and gave Council the latest data from the AMA on legislative matters.

*Report of State Legislative Committee:* Dr. Rogers emphasized doctor participation in state legislation and active support in county medical societies where a doctor runs for office. He reviewed the bills which were of interest and concern to the Medical Association of Georgia during the recent session of the General Assembly.

On motion duly made and seconded Council voted to approve the legislative report as a whole.

*Report of Speaker of House:*—Dr. Walker reported that the actions of the House at the 1965 Annual Session are being, or have been, implemented.

*Report of AMA House of Delegates Actions Requiring State Implementation:*—Dr. Chambers, Chairman of the MAG Delegation, asked for Council decision of the following AMA House of Delegates actions at the November 28-December 1, 1965 session, and the action taken is indicated after each:

I. *Public Response to Statements Discrediting Medicine:* Refer to Public Service Board for such implementation as necessary.

II. *P.L. 89-239—The Heart Disease, Cancer and Stroke Amendments of 1965:* Refer to MAG Board of Medical Education.

III. *Medical Staff Utilization Committee and Medical Society Review Committee:* Refer to Chairman, MAG Ad Hoc Committee on Hospital Utilization Review Guidelines.

IV. *Physicians Hospital Privileges:* Received for information and refer to the Hospital Relations Board.

V. *Perinatal Study Committees in Hospitals:* Refer to the Maternal and Infant Welfare Committee for implementation.

VI. *Hospital Staff Privileges for Allied Health Profession:* Refer to the Executive Committee for study.

VII. *Hospital Signs on Highways:* Refer to the Legislative Board.

VIII. *Physician Representation on Hill-Burton Hospital Advisory Councils:* Refer to Dr. A. B. Conger, Columbus, MAG representative on the Hospital Advisory Council for Construction, Licensure and Indigent Care, for whatever additional information he desires from the Council.

IX. *Request for Guidance in Establishing Hospital Facilities for Emergency and Acutely Ill Patients:* Refer to Dr. Napier Burson, MAG Ad Hoc Committee on Areawide Hospital Planning.

X. *Effect Upon Population Restlessness of Overcrowded and Unsanitary Living Conditions:* Refer to Dr. Napier Burson.

XI. *Health Education in Colleges and Universities:* Refer to Dr. Allen McDonough, Chairman, Georgia Youth Council Advisory Committee.

*State Board of Health Report:*—Dr. B. W. Forester, member of the State Board of Health, reported that the Board is operating now on a committee system which is functioning very well. He called for MAG to nominate responsible and capable members to the Board in the future. He strongly urged that the Mental Health Division not be set up as a separate autonomous Division of Mental Health within the State Department of Public Health but continued as a division under the State Department of Health. The appointment of Utilization Review Committees was urged.

Dr. Forester asked that a resolution to the MAG House of Delegates in the form of a Supplemental Report from Council to endorse the retention of the Division of Mental Health under the State Department of Health, be approved. On motion (Alexander-Walker) this request was approved.

The question of the State Board of Health giving approval to hospitals that qualify for participation under the new "medicare" law was brought up, and after discussion, the following action was taken: On motion (Mauldin-Jolley) Council voted to inform the State Board of Health to give tentative approval to hospitals that have reasonable evidence of qualification for participation under the new "medicare" law, which becomes effective July 1, 1966.

*MAG 1966 Annual Session:*—Mr. Krueger announced that:

(a) Hotel reservations for Officers, Councilors, Vice Councilors, and Official Family would be mailed within the next few days.

(b) The Annual Session program would be in the March issue of *JMAG*.

(c) Executive Committee recommended the following to receive Certificates of Appreciation: President; First Vice President; Secretary; AMA Delegate Tift; Councilors (not renominated); Thomas W. Goodwin; Charles H. Richard-Woody, Jr.; Mrs. Bruce Schaefer; Charles B. Watkins; Frankson; Auxiliary President; Thomas N. Lumsden; Edgar P. Holder, Jr.; Carl P. Savage, Sr.; A. Sidney Johnson, Sr.; J. Lee Walker; Harry B. O'Rear; Arthur P. Richardson; and Peter Zack Geer. On motion (Alexander-Bohler) Council voted to approve the above named to receive Certificates of Appreciation at the Annual Session in Columbus.

*Voting Hours at Annual Session:*—On motion (Walker-Alexander) it was voted to have the ballot box open for voting one hour after the adjournment of the General Business Session on May 8; and from 9:00 a.m. to 6:00 p.m., on May 9.

*Mead Johnson Scientific Exhibit Award:*—Dr. Alexander presented the offer of a cash award for scientific exhibits by Mead Johnson. Council voted to accept the award, and to so inform the company.

*Headquarters Office Report:*—Mr. Krueger reported on the following:

(a) *Office Management Survey* and Executive Committee's recommendations.

(b) *Formation of New County Medical Society:* Members of Barrow County have requested to be chartered as a county medical society and have submitted a Constitution and Bylaws for approval, which the Attorney has reviewed. Council then voted to grant the charter.

(c) *Councilor Redistricting:* Several of the districts have not reported the results of their elections and the councilors were asked to assist in getting this information. The various county medical societies in the new districts were read for information.

(d) *Fourth and Fifth District Proration of Dues Previously Collected:* The attorney recommended that the proration of dues already collected in the Fourth and Fifth District Societies be prorated according to the number of members in each county involved, i.e., Fulton, DeKalb and Rockdale. On motion (Wilson-Bohler) it was voted to approve this recommendation on the proration of the Fourth and Fifth District Societies dues.

(e) *AMA Delegates:* The delegates and alternate delegates, according to AMA, should be elected on a two and two basis and because there are three delegates whose terms of office come up for election this year, one of these should plan to run for one year, and that would then put our four delegates on a two and two basis. On motion Council voted to approve the one year term for one delegate this year.

The attorney was asked to rule on whether an alternate delegate whose term does not expire, can run for the position of delegate without resigning as alternate delegate. On motion (Alexander-Collins) Council voted that anyone running for another office must resign from the one he holds if his term of office extends beyond the time of elections.

(f) The Councilors were asked to promote the sale of commercial exhibit space at the forthcoming Annual Session.

## OLD BUSINESS—

(a) *Georgia Joint Council to Improve Health Care of Aged:* Dr. Atwater stated that the Council voted to assume a committee status and function on a standby basis at the call of the Chairman of the committee. On motion (Atwater-Alexander) Council voted to receive this report for information and incorporate a copy of the minutes of the last meeting of the Council in the minutes of the MAG Council meeting.

(b) *Voting Privileges at Annual Session:* Dr. Alexander reminded Council of the problem of delinquent dues and voting privileges and read from the Constitution and Bylaws regarding same. He asked that a letter be mailed to the county medical society secretaries quoting that Bylaws section over his signature. In the letter it should be stated, however, that dues can be paid through channels during the opening of the Annual Session.

## NEW BUSINESS—

(a) *Future Annual Session Meetings:* Dr. Alexander read a letter from Dr. Simone Brocato regarding the annual ses-



## SUMMARY OF MINUTES / Continued

sion meetings in the future and reported that the Executive Committee recommended reference to the Annual Session Board. Approved.

(b) *Annual Leadership Conference*: Another letter from Dr. Brocato was read about holding this conference at the time of the Annual Session. The Executive Committee recommended that Dr. Brocato be given an explanation that the conference must be held in January for the newly elected county society officers. Approved.

(c) *U. S. Chamber of Commerce Leadership Conference*: Mr. Moffett informed Council that on March 28 a Leadership Conference will be held in Atlanta and asked any Council members interested to attend.

(d) *Authorization for Change in Name of County Medi-*

*cal Society*: Jackson requested that the name of the county society be known as Jackson-Banks now that Barrow has become a county society. Approved by Council.

(e) *Voluntary Health Agency Conference Report*: Dr. Scoggins reported on his attendance at the AMA meeting on National Voluntary Health Agencies. It was stressed that a physician should be on each voluntary health agency in the state. Received for information.

(f) *Florida Medical Association Fraternal Delegates*: Dr. Alexander asked for name of anyone interested in attending the Florida Medical Association Annual Session, but their meeting follows the MAG Annual Session so closely we cannot send a delegate.

(g) *Letter of Sympathy to Dr. Peterson*: Council was informed that Dr. Peterson's brother had died and a letter of sympathy is to be written.

## AMA ANNOUNCES THIRD ANNUAL MEDICAL JOURNALISM AWARDS

The American Medical Association has announced its third annual \$5,000 medical journalism awards program "to recognize journalism that contributes to a better public understanding of medicine and health in the United States."

Awards of \$1,000 each will be presented for outstanding reporting on health and medicine in five categories—newspapers, magazines, radio, television, and in newspaper and broadcast editorial writing.

### Awards Presented in 1967

The awards are intended for recognition of outstanding reporting of the scientific and clinical aspects of medicine. Awards will be presented in 1967, based on work published or broadcast during the calendar year of 1966.

Entries will be judged on a basis of accuracy, significance, quality, public interest, and impact. Entries will be judged by the 1966 AMA Medical Journalism Awards Committee, which will include outstanding members of the publishing industry, radio and television industry, and the medical profession.

Entries may be sent to the 1966 Medical Journalism Awards Committee, American Medical Association, 535 N. Dearborn St., Chicago, Ill. Deadline is February 1, 1967, although entries may be submitted at any time prior to that date.

Newspaper and magazine articles should be submitted in triplicate, validating date of publication and showing the material as it was presented to the public. Entries for radio or television should consist of three copies of the complete script and a 200-word summary of the script, together with film or kinescope of television entries and audio tape or transcription of radio entries. Entrants may submit as many entries as they wish.

Each entry should be accompanied by a statement listing title of entry, writer or producer, publication in which the article appeared or station or network over which program was broadcast, date entry was published or broadcast, category for which entry is submitted, name, address and title of person submitting entry. Radio and television films, tapes or kinescopes will be returned if requested.

Categories of competition are:

1. **NEWSPAPERS**: For a distinguished example of a news or feature story or series in a United States newspaper of general circulation published daily, Sunday, or at least once a week.
2. **MAGAZINES**: For a distinguished example of an article or series in a United States magazine of general circulation published weekly, monthly, quarterly, or at other regular intervals.
3. **EDITORIALS**: For a distinguished example of editorial writing in a United States newspaper of general circulation published daily, Sunday, or at least once a week; or, for a distinguished example of editorial writing broadcast on a radio or television station.
4. **RADIO**: For a distinguished example of reporting on medicine or health on a United States radio station or network.
5. **TELEVISION**: For a distinguished example of reporting on medicine or health on a United States television station or network.

The awards will *not* be given for work, however excellent, that involves primarily the relaying of medical knowledge to the medical profession and to allied professions. Members of the medical profession, medical associations, and their employees are not eligible to submit entries.

## QUERIES ON NEW MEDICARE LAW ARE ANSWERED

*Excerpts from questions posed by physicians in attendance at the MAG County Medical Society Leadership Conference, February 5, 1966, as answered by representatives of the Social Security Administration on the new "Medicare" law, P.L. 89-97.*

(7) *What steps are being taken for certification of private laboratories?*

The Administration is completing work on the standards the State agency will apply in determining whether private laboratories meet the basic conditions for participation in the program. We expect completion of these standards soon.



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10,384	1964	88.5%

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2,492	1964	96.7%

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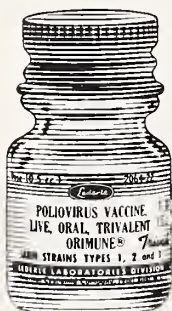
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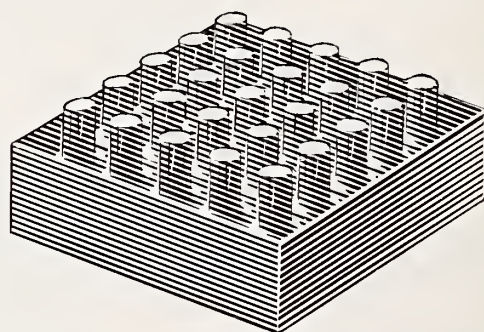
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\*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.



## 1966 ANNUAL SESSION *Highlights*

THE 112TH ANNUAL SESSION of the Medical Association of Georgia meeting in Columbus, May 8-10—drew a representative attendance of physicians and guests from all parts of the state. In format, the 1966 meeting was experimental. Idle, or “free” time was completely eliminated so as to compact the necessary meetings of the House of Delegates, General Business meetings and a full scientific program into a two and a half day period. A special session devoted exclusively to the new “medicare” program drew in excess of 340 persons, as a parade of experts reported the latest information on the implementation of this program.

Intra-association political activity attracted considerable attention as new officers and AMA Delegates and Alternates were elected.

*Among the many reports and resolutions presented to the House of Delegates for consideration were: separation of hospital based physician's fees from hospital charges; retention of mental health facilities and patient care program under direction of the State Board of Health; opposition to governmental efforts to regulated hospital admission policies; statutory expansion in the field of physician-patient confidential communications; AMA dues increase; employment of an MAG field service representative; increases in nurses salaries; direct billing of patients; burn center study committee; and changes in the fee schedule negotiating committee created by the 1965 House of Delegates.*

### Separation of Physician's Fees

The matter of percentage contracts between physicians and hospitals was presented to the House in the form of a resolution from the Cobb County Medical Society. This resolution sought to have defined as unethical any percentage contract or other arrangement whereby the hospital shared in the professional fee of a physician. The Reference



New MAG President-Elect, John T. Mauldin, left, of Atlanta, former Secretary of the Association, congratulates newly installed MAG President, Walter E. Brown, Savannah.

Committee report on this matter recommended against defining such an arrangement as unethical and further recommended against the creation of a committee to dispense information and assist in the implementation of “separate billing” policies. The House rejected the Reference Committee report and voted its approval of this resolution with minor editorial changes.

In a separate but allied action the House adopted another resolution which said in effect that the fees of hospital based physicians should not be merged with hospital charges, but should be established, billed and collected in the same manner as are the fees of other physicians. This resolution also provided that all hospital laboratories should be under the direction of a pathologist, and that all independent clinical pathological laboratories be under the direction of a pathologist or other qualified physician.

### Separate-Autonomous Mental Health Department

On the subject of creating a separate and autonomous Division of Mental Health the House was presented with one resolution and two supplemental reports, each of which

counseled against the creation of such a separate Division. The House adopted all three reports. In voting its approval of the Supplemental Report of the Mental Health Subcommittee, the House also went on record in favor of urging the earliest possible transfer of patients from the Milledgeville Hospital to other facilities; quick construction of the Mental Retardation Institute and the regional mental hospitals at Atlanta and Augusta; and the provision of funds to adequately staff these and additional psychiatric hospitals.

### Hospital Admission Policies

A resolution offered by the Spalding County Medical Society, critical of governmental efforts to influence hospital admission policies, was approved by the House. As passed, this resolution puts MAG in opposition to efforts by federal agencies to formulate hospital admission policies without regard to the interest of patient care. It also voted to have this resolution presented to the AMA House of Delegates.

### Physician-Patient Confidential Communications

The House voted its approval of a resolution presented by the Geor-



gia Medical Society (Chatham County) which called for an expansion of the legal category of confidential communications which may be excluded from public policy. Under the provisions of this resolution, MAG went on record favoring expansion of the confidential communication concept to include such communications between physician and patient except such as may be released by authority of the patient.

### AMA Dues Increase

The Reference Committee report on the activities of the AMA Delegates recommended that the House instruct the Delegates to vote for an increase in the AMA annual dues of \$25 at the June, 1966, meeting of the AMA House. The Reference Committee recommendation was based on information obtained from the Delegates to the extent that the AMA Board of Trustees would request such an increase at the 1966 AMA Annual Convention; and that there exists financial justification for this increase. The MAG House concurred with the Reference Committee and voted its approval.

### MAG Field Service Representative

In voting its approval of the report of the MAG Secretary, the House gave the "green light" to the employment of a field service representative for MAG. Taking note of the fact that this should be done to help establish and improve relationships among the component county medical societies, the House approved this recommendation contingent upon the availability of funds.

### Increase Nurses Salaries

A resolution urging the upgrading of salaries for nurses was presented

and reported from Reference Committee without change. The House voted its approval of this resolution urging hospital governing bodies to take effective steps toward offering salary increases to nurses and other paramedical personnel in an effort to eliminate critical shortages in these fields.

### Direct Billing

In voting its approval of a resolution dealing with direct patient billing as opposed to "assignment," the House adopted a floor amendment so that the "Resolved" portion of the resolution read: "... that the Medical Association of Georgia oppose any action by any third party to interfere with the prerogative of the physician to bill his private patient directly for services rendered. The method of billing patients directly instead of accepting assignment is more consistent with the maintenance of the close relationship between the physician and the patient."

### Burn Center

A supplemental report calling for the Medical Association of Georgia to petition the University System Board of Regents and the Medical College of Georgia to organize a "burn center" was reported from reference committee with the recommendation that the matter be approved in principal and referred to an appropriate committee for study. This was approved by the House.

### Fee Schedule Negotiating Committee

A special reference committee created by the 1965 House of Delegates for the purpose of devoting its full attention to the matter of fee

schedule negotiating recommended that the name of the committee be changed to "The Medical Review and Negotiating Committee of the Medical Association of Georgia," and that the present composition of the committee be retained. Two floor amendments were offered and adopted. The first, put MAG on record as endorsing the AMA concept of the payment of the usual and customary fees in dealing with third parties, also taking note of the fact that changing economic standards will necessitate changes in the usual and customary fees periodically; and the second proposed that the Georgia Chapter of the American Association of Public Health Physicians not be represented on this Committee. The House adopted this report as amended.

### Awards Presented

Henry Homer Allen, II, M.D., Decatur, was awarded a certificate as the "General Practitioner of the Year," Dr. P. P. Volpito, Augusta, was presented with the Hardman Certificate and Cup. "Prosthetic Replacement for Aortic Valve Disease," by Drs. Robert G. Ellison, Thomas Yeh, Isam Anabtawi, and V. E. Carnett, Augusta, took first place in the Scientific Exhibit Awards.

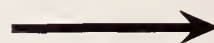
### New Officers

The following new officers for the coming year were elected and/or installed at the 1966 Annual Session: Walter E. Brown, Savannah, President; John T. Mauldin, Atlanta, President-Elect; J. Rhodes Haverty, Atlanta, Secretary; and M. C. Adair, Washington, Second Vice President. John S. Atwater, Atlanta, was elected to succeed Dr. Henry Tift as AMA Delegate.

## OFFICIAL PROCEEDINGS

112th Annual Session—Medical Association of Georgia

Columbus, Georgia, May 8-10, 1966





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### First

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# FIRST SESSION, HOUSE OF DELEGATES

MONDAY, MAY 9, 1966

**T**HE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker J. Frank Walker, Atlanta, at 9:45 a.m., in the Municipal Auditorium, Columbus, Georgia, on May 9, 1966, in conjunction with the 112th Annual Session of the Medical Association of Georgia.

Speaker Walker announced that he had received a preliminary report of delegates' attendance from the House of Delegates Credentials Committee and that there was a quorum of over 40 members present and accounted for. A complete report made by the Credentials Committee on the attendance at the First Session of the House of Delegates follows:

## Attendance

In a compilation of attendance taken from the official roll, 42 county medical societies were represented by their duly elected delegates or alternates. Thirty-two medical societies were not represented at this First Session. Of a total of 157 authorized delegates from their respective medical societies, the official roll showed 111 delegates present at this First Session.

BALDWIN: A. C. Martinez; BIBB: J. T. Hogan, Milton I. Johnson, F. V. Kay, H. F. Smisson, Charles R. White; BLUE RIDGE: Charles B. Watkins; BULLOCH-CANDLER-EVANS: John D. Deal; BURKE: J. M. Byne, Jr.; CAMDEN-CHARLTON: J. M. Jackson; CARROLL-DOUGLAS-HARALSON: Phil C. Astin, J. Harvey Beall; GEORGIA MEDICAL: John L. Elliott, William H. Fulmer, Lee Howard, Jr., Lawrence Lee; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: George Erwin, F. M. McElhannon, R. E. Shiflet; CLAYTON-FAYETTE: Clyde Harrison; COBB: Remer Y. Clark, Ralph W. Fowler, James H. Manning, Stephen May, Donald R. Rooney; DECATUR-SEMINOLE: Henry A. Bridges; DEKALB: E. C. Atkins, H. H. Butterworth, Robert Hubbell, Z. V. Morgan, Benjamin B. Okel; DOUGHERTY: W. P. Rhyne; EMANUEL: Robert J. Moye; FLINT: J. T. Christmas; FLOYD: A. Richard Gray, Richard W. Leigh, James H. Smith; FULTON: John S. Atwater, Spencer S. Brewer, G. S. Clinkscales, F. William Dowda, Edwin C. Evans, Joseph L. Girardeau, John T. Godwin, Irving L. Greenberg, L. Harvey Hamff, J. Frank Harris, J. Harold Harrison, J. Rhodes Haverty, J. H. Hilsman, James A. Kaufmann, J. Watts Lipscomb, William D. Logan, Jr., John N. McClure, J. G. McDaniel, J. D. Martin, Lamar B. Peacock, A. A. Rayle, Jr., Harrison L. Rogers, Jr., Lester Rumble, Jr., J. K. Shellack, Charles E. Todd, J. Frank Walker, Robert E. Wells, Frank L. Wilson, Joseph S. Wilson; GLYNN: C. S. Britt, Clyde A. Wilson, Jr.; HALL: Robert Anderson, Billy S. Hardman; PEACH BELT: Francis M. Lindsey, H. E. Weems; JACKSON-BARROW: E. W. Holloway; LAURENS: Fred J. Coleman; MUSCOGEE: Louis A. Hazouri, G. Bertling Smith, Calvin Thrash; POLK: Don Schmidt; RICHMOND: Preston D. Ellington, John R. Fair, William A. Fuller, R. F. Galloway, Menard Ihnen, Julius T. Johnson, Jack B. Lindley, Henry D. Scoggins, Walter L. Sheppard, Cecil A. White, Jr.; SOUTH GEORGIA: Russell

Acree, Fred C. Smith, S. H. Story; SOUTHEAST GEORGIA: M. H. Whittle; SPALDING: Alex P. Jones, James Skinner; STEPHENS: I. D. Hellenga; SUMTER: John H. Robinson, III; TELFAIR: C. J. Maloy; THOMAS-BROOKS: Robert T. Cain, F. R. Miller; TROUP: H. Hilt Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: M. K. Cureton, Fred H. Simonton; WARE: F. E. Davis, L. C. Durrence; WAYNE: Ollie O. McGahee; WHITFIELD: R. T. Farrow, D. A. Wells; WILKES: M. C. Adair.

## Credentials and Tellers Committees

Speaker Walker announced the prior appointments of the House of Delegates Credentials Committee and Tellers Committee as follows:

CREDENTIALS COMMITTEE: W. W. Osborne, Savannah, Chairman; C. A. Wilson, Brunswick; and Cecil White, Augusta

TELLERS COMMITTEE: Fleming Jolley, Atlanta, Chairman; T. L. Edmondson, Tifton; and Henry Bridges, Bainbridge

## Reference Committees

Speaker Walker appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE NO. 1: Alex Jones, Griffin, Chairman; J. H. Beall, Carrollton, Vice Chairman; Lee Howard, Jr., Savannah, Secretary; J. Rhodes Haverty, Atlanta; S. H. Story, Valdosta; John R. Fair, Augusta; and Virginia Hamilton, Cartersville.

REFERENCE COMMITTEE NO. 2: Henry Scoggins, Augusta, Chairman; William G. Sutlive, Savannah, Vice Chairman; H. Hilt Hammett, Jr., LaGrange, Secretary; Albert Rayle, Atlanta; Walter Voyles, Waynesboro; John Deal, Statesboro; and John Robinson, Americus.

REFERENCE COMMITTEE NO. 3: W. P. Rhyne, Albany, Chairman; J. Watts Lipscomb, Forest Park, Secretary; Robert Moye, Swainsboro; A. Richard Gray, Rome; Milton Johnson, Macon; Irving Greenberg, Atlanta; and Don Schmidt, Cedartown.

REFERENCE COMMITTEE NO. 4: Roy Gibson, Columbus, Chairman; John B. O'Neal, Elberton, Vice Chairman; I. D. Hellenga, Toccoa, Secretary; Spencer Brewer, Atlanta; Francis Lindsey, Warner Robins; John M. Miller, Valdosta; and Julius Johnson, Augusta.

REFERENCE COMMITTEE NO. 5: John Godwin, Atlanta, Chairman; Charles R. White, Macon, Vice Chairman; T. A. Sappington, Thomaston, Secretary; Billy Hardman, Gainesville; Randolph Malone, Thomasville; M. K. Cureton, LaFayette; and Benjamin Okel, Decatur.

Speaker Walker then noted that the 1965 House of Delegates set up a "Fee Schedule Negotiating Committee" and recommended that this Committee report their activities to a special Reference Committee set up for that purpose only. Speaker Walker then appointed Reference Committee No. 6.

REFERENCE COMMITTEE NO. 6: Charles Watkins, Ellijay, Chairman; Robert Hubbell, Decatur, Vice Chairman; William Logan, Atlanta, Secretary; Fred Coleman, Dublin; Joseph Wilson, Atlanta; F. E. Davis, Waycross; and Menard Ihnen, Augusta.



## Approval of 1965 Minutes

To expedite the reading and adoption of the minutes of the 1965 Sessions of the House of Delegates held in conjunction with the 111th Annual Session of the Medical Association of Georgia meeting May 2-4, 1965, at Augusta, Georgia, the chair entertained a motion that the minutes as published in the June, 1965, issue of the *Journal of the Medical Association of Georgia* be approved. On motion duly made and seconded, it was voted that these minutes be so approved as published in their entirety in the June, 1965 issue of the *JMAG*.

## Annual Reports

Speaker Walker called for the Annual Reports of Officers, Council, Councilors and Vice Councilors, Association Committees and Boards and Subcommittees. The reports of Officers, Council, Councilors and Vice Councilors, Association Committees and Board and Board Subcommittees, and Allied Reports as introduced at this Session are listed below with the Reference Committees to which they were referred. The full report; the action by the Reference Committee; and the House of Delegates action is listed under the proceedings of the Second Session of the House of Delegates. (See pages 213 to 263.)

### OFFICERS

President—Reference Committee No. 3  
President-Elect—Reference Committee No. 1  
Immediate Past President—Reference Committee No. 1  
First Vice President—Reference Committee No. 1  
Second Vice President—Reference Committee No. 1  
Secretary—Reference Committee No. 1  
Treasurer—Reference Committee No. 1  
Speaker of the House—Reference Committee No. 1  
Vice Speaker of the House—Reference Committee No. 1  
AMA Delegates—Reference Committee No. 2  
AMA Alternate Delegates—Reference Committee No. 2

### COUNCIL

Council of MAG—Reference Committee No. 2

### COUNCILORS AND VICE COUNCILORS

First District Councilor—Reference Committee No. 2  
Second District Councilor—Reference Committee No. 2  
Second District Vice Councilor—Reference Committee No. 2  
Third District Councilor—Reference Committee No. 2  
Fourth District Councilor—Reference Committee No. 2  
Fifth District Councilor—Reference Committee No. 1  
Sixth District Councilor—Reference Committee No. 1  
Seventh District Councilor—Reference Committee No. 3  
Eighth District Councilor—Reference Committee No. 3  
Ninth District Councilor—Reference Committee No. 3  
Ninth District Vice Councilor—Reference Committee No. 3  
Tenth District Councilor—Reference Committee No. 3  
Georgia Medical Society Councilor—Reference Committee No. 2  
Georgia Medical Society Vice Councilor—Reference Committee No. 2  
Muscogee County Medical Society Councilor—Reference Committee No. 4  
Fulton County Medical Society Councilor—Reference Committee No. 1  
Fulton County Medical Society Vice Councilor—Reference Committee No. 1

Bibb County Medical Society Councilor—Reference Committee No. 1

Bibb County Medical Society Vice Councilor—Reference Committee No. 1

Richmond County Medical Society Councilor—Reference Committee No. 4

Richmond County Medical Society Vice Councilor—Reference Committee No. 4

### ASSOCIATION COMMITTEES

Finance—Reference Committee No. 2

### BOARDS AND SUBCOMMITTEES

Annual Session Board—Reference Committee No. 4  
Constitution and Bylaws Board—Reference Committee No. 3  
Governmental Medical Services Board—Reference Committee No. 4  
Crippled Children's Subcommittee—Reference Committee No. 4  
Disaster Medical Care Subcommittee—Reference Committee No. 5  
Maternal and Infant Welfare Subcommittee—Reference Committee No. 5  
Blood Bank Subcommittee—Reference Committee No. 4  
Insurance and Economics Board—Reference Committee No. 5  
Interprofessional Relations Board—Reference Committee No. 4  
Nursing Liaison Subcommittee—Reference Committee No. 5  
Legislation Board—Reference Committee No. 4  
Medical Education Board—Reference Committee No. 5  
AMA-ERF Subcommittee—Reference Committee No. 5  
Rural Health Subcommittee—Reference Committee No. 1  
Public Service Board—Reference Committee No. 5  
Medicine and Religion Subcommittee—Reference Committee No. 5  
Special Activities Board—Reference Committee No. 4  
Voluntary Health Agencies Board—Reference Committee No. 4  
Mental Health Subcommittee—Reference Committee No. 5  
MAG Fee Schedule Negotiating Committee—Reference Committee No. 6

### ALLIED REPORTS

Report of the *Journal*—Reference Committee No. 5  
Report of the Woman's Auxiliary to the MAG—Reference Committee No. 2

## General Practitioner of the Year Award

Speaker Walker presented the two nominations for the 1966 Georgia "General Practitioner of the Year" Award as received from the Association's First General Business Session. The two nominees presented were: Charles H. Dickens, of Madison, and H. Homer Allen, Decatur. Dr. Walker then asked the Delegates to mark their "GP of the Year" ballot with the name of the candidate of their choice for this high honor. Tellers Committee Chairman Fleming Jolley then reported that Dr. H. Homer Allen, of Decatur, Georgia, had been elected the 1966 "General Practitioner of the Year," and Speaker Walker announced that this award would be presented at the final MAG Business Session, May 10.

## Late Reports

Speaker Walker announced as the first order of unfinished business, he wished to present and refer Late Reports received after the deadline for the printing of the Delegates Handbook. These late re-



ports as received and referred to Reference Committee are as follows:

Late Report 1: Third District Vice Councilor—Reference Committee No. 2  
Late Report 2: Fulton County Medical Society Councilor—Reference Committee No. 1  
Late Report 3: School Child Health Subcommittee—Reference Committee No. 4  
Late Report 4: Professional Conduct Committee—Reference Committee No. 1  
Late Report 5: Hospital Activities Board—Reference Committee No. 1  
Late Report 6: Talmadge Hospital Liaison Committee—Reference Committee No. 5

### Supplementary Reports

Speaker Walker announced that as the second order of unfinished business, he wished to present Supplementary Reports for referral to a House Reference Committee. Dr. Walker stated that as supplementary report adds something new to an existing report previously submitted, he would therefore refer these supplementary reports to the same Reference Committee that received the original report if possible. The following Supplementary Reports were then referred as follows:

Supplementary Report A: MAG President—Medical Ethics Conference—Reference Committee No. 3  
Supplementary Report B: MAG Council—Autonomous Division of Mental Health—Reference Committee No. 4  
Supplementary Report C: Fee Schedule Negotiating Committee—Current Status with Third Party Negotiations—Reference Committee No. 6  
Supplementary Report D: Insurance and Economics Board—Professional Liability Insurance—Reference Committee No. 5  
Supplementary Report E: Nursing Liaison Subcommittee—Nursing Activities Survey—Reference Committee No. 5  
Supplementary Report F: Mental Health Subcommittee—Mental Health—Reference Committee No. 4  
Supplementary Report G: MAG Council—Burn Center—Reference Committee No. 5

### Incoming President's Address

Speaker Walker stated that as the last item of unfinished business, he wished to refer the address of President-Elect Walter Brown, Savannah, which was presented at the MAG Second General Business Session.

President-Elect's Address—Reference Committee No. 1

### Resolutions

Speaker Walker stated that at this time, the House would consider new business which concerns the introduction of Resolutions. The following resolutions were then presented:

Resolution No. 1: Separation of Physician's Professional Fee From Hospital Charges—Reference Committee No. 5  
Resolution No. 2: MAG Establish Policy Concerning Relations Between Government and Medical Practitioners—Reference Committee No. 2  
Resolution No. 3: Physician-Patient Confidential Relationship—Reference Committee No. 4  
Resolution No. 4: Mental Health Board—Reference Committee No. 4  
Resolution No. 5: Direct Billing—Reference Committee No. 5  
Resolution No. 6: Separate Anesthesiology, Pathology and Radiology Fee From Hospital Services—Reference Committee No. 5  
Resolution No. 7: Hospital Operating Policies—Reference Committee No. 2  
Resolution No. 8: Increase Nurses Salaries—Reference Committee No. 5  
Resolution No. 9: Eye Research—Reference Committee No. 2  
Resolution No. 10: Designation of Appointee to MAG Fee Negotiating Committee—Reference Committee No. 6

Speaker Walker called for other Resolutions, and there being none, the First Session of the MAG House of Delegates was recessed, on motion duly made and seconded at 10:25 a.m.

## SECOND SESSION, HOUSE OF DELEGATES

(RECESSED)

TUESDAY, MAY 10, 1966

THE SECOND SESSION (Recessed) of the House of Delegates of the Medical Association of Georgia held in conjunction with the 112th Annual Session of the Association was called to order by Speaker J. Frank Walker, at 10:00 a.m., in the Municipal Auditorium, Columbus, Georgia, on May 10, 1966.

Speaker Walker announced that the Credentials Committee Chairman reported an attendance in excess of 40 members registered and accounted for, therefore, Dr. Walker declared a quorum present

and the House of Delegates in session. The Credentials Committee made the following complete report on attendance at the close of the meeting.

### Attendance

In a compilation of attendance from the official roll, 40 county medical societies were represented by their duly elected delegates or alternates. Thirty-four medical societies were not represented at this Second Session. Of a total of 157 authorized dele-



gates from their respective medical societies, the official roll showed 107 delegates present at this Second Session.

BIBB: J. T. Hogan, Milton I. Johnson, F. V. Kay, H. F. Smisson, Charles R. White; BLUE RIDGE: Charles B. Watkins; BULLOCH-CANDLER-EVANS: John D. Deal; CAMDEN-CHARLTON: J. M. Jackson; CARROLL-DOUGLAS-HARALSON: Phil C. Astin, J. Harvey Beall; GEORGIA MEDICAL: John L. Elliott, Lee Howard, Jr., Lawrence Lee, W. W. Osborne, William G. Sutlive; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: George Erwin, F. M. McElhannon; COBB: Remer Y. Clark, Ralph W. Fowler, James H. Manning, Stephen May, Donald R. Rooney; DECATUR-SEMINOLE: Henry A. Bridges; DEKALB: E. C. Atkins, Robert Hubbell, Z. V. Morgan, Benjamin B. Okel; DOUGHERTY: A. M. Freeman, W. P. Rhyné, R. D. Waller; EMANUEL: Robert J. Moye; FLINT: J. T. Christmas; FLOYD: A. Richard Gray, Richard W. Leigh, James H. Smith; FULTON: John S. Atwater, Spencer S. Brewer, G. S. Clinkscales, F. William Dowda, Edwin C. Evans, Joseph L. Girardeau, John T. Godwin, Irving L. Greenberg, L. Harvey Hamff, J. Frank Harris, J. Harold Harrison, J. Rhodes Haverty, Fleming L. Jolley, James F. Kaufmann, Jr., J. Watts Lipscomb, William D. Logan, Jr., John N. McClure, J. G. McDaniel, William W. Moore, W. Perrin Nicholson, III, Lamar B. Peacock, A. A. Rayle, Jr., Harrison L. Rogers, Jr., Lester Rumble, Jr., J. K. Shellack, Charles E. Todd, J. Frank Walker, Robert E. Wells, Frank L. Wilson, Joseph E. Wilson, Edgar Woody, Neil G. Perkinson; GLYNN: Clyde A. Wilson, Jr.; HALL: Robert Anderson, Billy S. Hardman; PEACH BELT: Francis M. Lindsey; JACKSON-BARROW: E. W. Holloway; LAURENS: Fred J. Coleman; MUSCOGEE: Jack McGee, G. Bertling Smith, Calvin Thrash; POLK: Don Schmidt; RICHMOND: William Barfield, Preston D. Ellington, William A. Fuller, R. F. Galloway, Julius T. Johnson, Jack B. Lindley, Ben Moss, Henry D. Scoggins, Walter L. Sheppard, Cecil A. White, Jr.; SOUTH GEORGIA: Fred C. Smith, S. H. Story; SOUTHEAST GEORGIA: M. H. Whittle; SOUTHWEST GEORGIA: Homer L. Lassiter; SPALDING: Alex P. Jones, James Skinner; STEPHENS: I. D. Hellenga; SUMPTER: John H. Robinson, III; TELFAIR: C. J. Maloy; THOMAS-BROOKS: Robert T. Cain; TROUP: H. Hilt Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: M. K. Cureton, Fred H. Simonton; WARE: F. E. Davis, L. C. Durrence; WAYNE: Ollie O. McGahee; WHITFIELD: R. T. Farrow, D. A. Wells; WILKES: M. C. Adair.

## Reference Committee Reports

Speaker Walker stated that the next order of business would be the Reference Committee Reports as follows:

### Report of Reference Committee No. 1

Alex Jones, Griffin, Chairman

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)*

Reference Committee No. 1 met in Room 319, of the Ralston Motor Hotel, Columbus, Georgia, at 2:30 p.m., May 9, 1966. Members present were: Alex Jones, Griffin, Chairman; J. H. Beall, Carrollton, Vice Chairman; Lee Howard, Jr., Savannah, Secretary; J. Rhodes Haverty, Atlanta; S. H. Story, Valdosta, and John R. Fair, Augusta.

## President-Elect

WALTER BROWN, M.D., Savannah

During the past year I have attended all meetings of the Executive Committee and Council.

I also attended the following:

June 1965: AMA annual meeting in New York.

August 1965: Presidents and Presidents-Elect meeting in Chicago.

January 1966: AMA Legislative program in Chicago.

February 1966: Meeting of State Board of Health in Atlanta.

February 1966: Annual meeting of County Officers in Atlanta.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee recommends approval.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the President-Elect as recommended by the Reference Committee on motion duly made and seconded.

## President-Elect's Address

WALTER E. BROWN, M.D., Savannah

**M**EMBERS of the Medical Association of Georgia: Distinguished Guests and Welcome Visitors.

It is with a deep feeling of humility that I stand here before you today, knowing full well that there are here today many far more able and far more qualified to be in this position than myself. However, I will yield to none in making every effort and exercise all care and consideration in doing my part to further the interests of the Medical Association of Georgia and medicine in Georgia at all levels. So, as in humility, also, I come in pride that you have seen fit to name me as your president.

After many years in our local society, Georgia Medical Society, in committee assignments and in council, it has become and is evident that our association is full grown in members, in influence and in scope of its activities.

These activities now encompass professional, social, legal, religious, charitable and humanitarian aspects of our society, and it will be our aim to continue to aid and cooperate with all these facets of our community life where compatible with our aim and efforts and not contrary to our teachings and beliefs.

It is more and more very evident that the operation and success of MAG is now no longer a small endeavor.

No one realizes more than I how much we are now dependent upon the active, efficient and willing cooperation of many MAG committees (who give freely of their valuable time) to further the advancement of medicine and medical care to all in Georgia.

This is in full manner also true of Council. The Executive Committee, the House of Delegates and in extra manner the efficient and ever helpful headquarters office staff, without whose help and guidance we could not function.

We are at a cross road today facing an entirely new concept and view to the future in the practice of medicine in this country which is totally foreign to our teaching, to our thinking and to how we will be called upon to conduct our practice and indeed in some areas as to how we shall conduct ourselves as physicians.

It is not necessary at this time to review in detail the



provisions and ramifications of the Medicare law. This has been adequately covered in repeated meetings and special called meetings of AMA and its appropriate committees. All this is well covered in our Journals and allied publications.

Suffice it to say that as one or all groups we cannot collectively refuse to abide by the law. However, as in the past, we as individual physicians may still choose and select those whom we desire to treat, and cannot be forced to care for anyone against our will. In this way, we can continue to maintain our close physician-patient relationship as we do now, and by our present method and such relationship offer the best medical care in the world.

We in MAG will abide by the law, but we will use all ethical and legal means at our disposal to prevent further encroachment of the Federal Government by law and regulation upon our profession and how we practice in the future. We have been told that the present law is only a beginning and that the aim of the Government is to rapidly expand the law to cover more and more of our population, so that I can foresee the total control of medical practice by Federal regulation.

At this point we urge for this reason that all of us make every effort to support and to contribute to GaMPAC and AMPAC, who are constantly on the alert and lookout for new and unfavorable legislation involving our profession, and to resist passage of such legislation by actively contacting our legislators, congressman and senators when requested to do so by MAG, AMA and our legislative committee. Likewise, to support favorable legislation and actively support candidates favorable to our views and aims. These should include members of our profession.

During the past year we have had productive and fruitful meetings with the State Board of Health, involving areas of mutual interest. At present a member of our Executive Committee meets with the Board monthly and a member of the Board attends our Council meetings. We shall continue to offer assistance and cooperation with Health Department and other state agencies working for continued improvement and expansion of activities in area of mental health programs in Georgia. To encourage expansion of facilities as rapidly as feasible.

Also, continue assistance in furthering the general health and welfare of our people. Administration of Medicare will be by the Health Department (John Hancock agent for title XVIII).

We are greatly concerned with the increasing and frightful toll of highway deaths in our country (49,000 dead and 1.8 million partially or totally disabled in 1965, 1,350 dead in Georgia, 19,000 injured, 35 million monetary losses). I feel that we should cooperate with Department of Public Safety and State Government in formulating and working for passage of more stringent traffic regulations, more safety features on new cars. Also, stricter requirements for driving licenses and stiff penalties for anyone convicted of drunken driving or repeated breaking of traffic laws. This has now become of medical importance.

We are becoming a very heavily industrialized state and soon the problem of air and water pollution will become of real importance. We should cooperate in study of this problem as it arises and offer assistance to the State Health Department (State and Local), to

civic organizations and to industry when such problems properly address themselves to us and fall within the scope of our activity.

With the advent of increased demand on our hospital facilities which will inevitably follow the activation of Medicare and increased welfare care of the aged and dependent we will surely find ourselves short in all areas of paramedical care and personnel to staff present and expanding hospitals, nursing and convalescent homes, and indeed our own offices and clinics. We should foster and encourage present programs and aid in setting up of new ones to train the number of persons who will be needed in the future. These will and should include training of nurses, nurses aides, laboratory technicians, x-ray technicians, office assistants, medical stenographers and etc.

In like manner we shall very rapidly fall even further short in the matter of educating new physicians. Even now there is an active program to increase the number of medical schools in this country as well as to enlarge present facilities so as to increase the number of graduates each year. We should be ever ready to assist and advise with our two great medical schools and to cooperate with them in whatever areas we can to implement such plans as they may now have or contemplate activating to increase the output of physicians in our state.

Emory University Medical School and the Medical College of Georgia are great assets and adjuncts to organized medicine in Georgia. They constantly work to keep abreast and ahead in instruction, to turn out well trained graduates, research programs and frequent short seminars and courses to aid us in keeping up to date with advances and newest changes in concepts of medical education and progress in all fields. They are always ready and anxious to provide speakers for our various county, district, state and specialty organizations and auxiliary organizations.

We are greatly concerned about the diminishing attendance at the annual meetings. Preparation for these is practically a year long effort, beginning soon after conclusion of each session. Dr. Spitzer, Chairman, and the annual sessions committee, the specialty groups and the many host society committees and headquarters office work diligently and long hours to organize and activate each meeting.

Much work and thought is given to preparing an interesting and revealing program, both scientific and social. Highly qualified speakers from all sections of the country are obtained for all specialty and general sessions and we should attend as many of these as possible. It is a source of concern for prominent guest speakers to appear before a very small number of our members. We have abbreviated the meetings, so as to cause a minimum loss of time from our practice and time away from home. We urge all members to make an extra effort not only to attend, but to take part in, and contribute to the success of each session, also, take part in election of officers. It is, after all, your organization and its growth and continued success and influence is dependent upon active participation of all members in all of its activities. Here we renew old acquaintances and make new friendships which last for many years.

We have another vital problem facing us, not only in Georgia but nationwide. This is the growing problem



of alcoholism. The number of alcoholics and chronic drinkers is ever increasing and this should address itself to all of us. Firstly for the impact it has on the health of the individual, secondly its effect on economics and moral aspect of those involved. Loss of income, broken families, loss of earning capacity, loss of self respect, moral degeneration, etc. We have now an active program of rehabilitation and aid to the alcoholic; State Hospital in Atlanta and several areas alcoholic clinics are doing excellent work. We should be ready to aid in every way available to us those who are working in this area, and cooperate in making more help available to those in need. Alcoholics Anonymous also is doing a fine job in aiding and encouraging those harassed and burdened by this problem.

Our State Vocational Rehabilitation program is a joint state and federal project. Primary aim is to correct or reduce and treat physically handicapped and to train permanently handicapped (blind, deaf, etc.) so that they may be gainfully employed or re-employed, thereby reducing the numbers of persons dependent on government or social agencies for maintenance and support. The Georgia program is outstanding. Has ranked in top three states in the nation for past 20 years. Last year 7,221 cases rehabilitated, most of whom are now totally or partially self supporting. These represent cases from more than 30 categories of handicaps.

Vocational Rehabilitation and Department of Family and Children's Services now have research and demonstration project to investigate and rehabilitate alleged disabilities of many on aid to disabled and aid to families of dependent children. Two of 27 such projects in nation now in Georgia (Atlanta and Savannah). I feel that the Vocational Rehabilitation program has made and is making great strides in health improvement and in adjustment of handicapped persons and that we should offer help and cooperation in its continued activity and expansion.

We approach an uncharted and uncertain course in the future practice of our profession. Many of the requirements already existing and to be formulated will be foreign to our precepts, concepts, and methods of established medical procedures and principles which we have so faithfully followed. Believing as we do, that our present system of medical care and practice is by far the best for the welfare of our patients, we will find it difficult to subscribe to and adjust to many radical changes which are certainly facing us. We shall endeavor to constantly bear in mind that our total thoughts and efforts shall continue to be directed at offering at all times the highest quality of medical care to those in need, and that nothing regulatory or directive shall divert or deter us from this purpose and determination.

May we seek and invoke divine guidance and direction for all of us in the fulfillment of our aims and efforts.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee recommends approval with the following comments: (1) It highly recommends the support and contribution of members of the MAG to GaMPAC and AMPAC; (2) It highly recommends the continuance of close liaison between MAG, the Georgia State Board of Health and the State Department of Public Safety; (3) It highly recommends close liaison between State Vocation Rehabilitation, Vocational Training Schools and the medical profession of this state in order to affect a complete rehabilitation of the handicapped.

**HOUSE OF DELEGATES ACTION**—Adopted the President-Elect's Address as recommended by the Reference Committee on motion duly made and seconded.

## Immediate Past President

J. G. McDANIEL, M.D., *Atlanta*

Your Past President has attended all of the Executive Committee and Council meetings throughout the past year. I also attended the AMA Annual Convention in June 1965 in New York City.

It has been my privilege to meet with the Chancellor of the University System and his committee on nursing on two occasions to discuss the feasibility of establishing a two year nursing program in the junior colleges. I am happy to report that such programs are about to be put in operation.

I have served with the President on several occasions on matters pertaining to Medicare. I have represented the Association at meetings concerned with automobile traffic safety. The Medical Association of Georgia should continue an active interest in this.

It has been a pleasure to serve this Association for the past three years as President-Elect, President and Past President. My interest in the Medical Association of Georgia will always remain at a high peak.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee recommends approval with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Immediate Past President as recommended by the Reference Committee on motion duly made and seconded.

## First Vice-President

HENRY S. JENNINGS, M.D., *Gainesville*

This year has brought about an increasing interest and concern in the activities of the Association. Attendance at all but two of the Executive Committee meetings, and participation in several telephone conference meetings of Executive Committee has served to further impress upon your First Vice-President the importance of your Association. All of the Council meetings have been attended and have been the source of many thought provoking ideas about the future of organized medicine. It is of some concern to your First Vice-President that the interest, time, and genuine dedication of a group of our colleagues (Council of MAG) is so little understood and appreciated by the membership of this great organization. These men (Councilors, Vice-Councilors, and Officers) are no less busy in the practice of medicine than the average member of MAG, yet they find, or make, the time to concern themselves with the business of our Association. The opportunity is available to every member of MAG to become more active in the deliberations and decisions that affect our profession.

It was the privilege and pleasure of the First Vice-President to represent President Alexander at the fall meeting of the 10th District Medical Society in Thomson.

In March, 1966, your First Vice-President represented MAG at a meeting of the Appalachian Regional Commission at Callaway Gardens. This meeting concerned itself with the establishment of demonstration health facilities in the Appalachian area of the United States, part of which encompasses a number of counties in North Georgia.



I would like to express appreciation to the members of MAG for the privilege of being allowed to serve as one of the officers of the Association for the past two years.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee recommends approval with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the First Vice President as recommended by the Reference Committee on motion duly made and seconded.

**Second Vice President**

LAMAR B. PEACOCK, M.D., *Atlanta*

It has been a pleasure to serve as Second Vice President during the past year, working behind an outstanding First Vice President, Dr. Henry Jennings. I have attended the Council meetings and participated in the business of the Council for the past twelve months.

At the request of our President, I attended in his behalf, the Seventh District meeting held at Dalton, Georgia in the fall of 1965. The Seventh District is very active and has an excellent group of physicians, a group of which all doctors can be proud. I extended our greetings from the Medical Association of Georgia to them.

At the request of the President, I attended the opening of the new Vocational Rehabilitation building at Warm Springs, Georgia and spoke in behalf of our organization, supporting the excellent work of the Vocational Rehabilitation Department.

I have no new suggestions concerning the job of Second Vice President. It is mainly a training ground for the job of First Vice President. I appreciate the privilege of serving the doctors of Georgia in this capacity.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee recommends approval with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Second Vice President as recommended by the Reference Committee on motion duly made and seconded.

**Secretary**

JOHN T. MAULDIN, M.D., *Atlanta*

Very few physicians realize that the practice of medicine in Georgia in a ninety to one hundred million dollar business. That the activities of your Medical Association are rapidly expanding to include in addition to the ethics and scientific portions of the practice of medicine to such other activities as fee negotiation with third parties, administration of federal and state medical programs, and politics. Thus the future of the practice of medicine will depend on united action through the Medical Association of Georgia.

In order to obtain better dissemination of information in both directions to and from county societies, and to encourage more activity in District Societies because of their political importance, it is recommended that the Council of the Medical Association of Georgia be instructed to study and prepare a long range plan for a field service and to implement these plans in a reasonable period of time.

**MEDICARE**

This program has functioned smoothly under the direction of Mrs. Joyce Butler.

The Fee Negotiating Committee of the Medical Association of Georgia has met with representatives of the Department of the Army in an effort to upgrade the fee schedule. These negotiations have not been completed at this time. The present plans are to extend the present contract for a period of three months, in order to complete the new schedule, rather than to delay a full year under the present contract. It is anticipated that these negotiations will be completed prior to May.

The following is a statistical report for the Office for Dependents' Medical Care (Medicare) for 1965.

		% Claims Received
Number claims received . . . .	16,187	
Number claims returned . . . .	2,895	18
Number of claims paid . . . .	12,227	75.5
Number of claims rejected . . . .	314	2
Number of claims adjudicated (Review Boards) . . . . .	121	1
Number of claims adjusted (above maximum allow- ance) . . . . .	1,900	12
Total amount paid . . . . .	\$984,241.50	
Average per claim . . . . .	80.50	
Average number of claims processed per working day . . . .	63.2	

**ADULT RECIPIENT PROGRAM**

The Medical Association of Georgia has continued to operate the evaluation portion of this program under contract with the Department of Family and Children Services. There have been no changes in the program during the year, and no hearings have been necessary for the purpose of adjudicating claims.

The following is a statistical report of the program's activities:

Number of new claims received . . .	29,104	
Number of returned claims received . . .	1,433	
		<hr/>
Total claims received . . . . .		30,537
Number of new requests received . . .	3,734	
Number of returned requests re- ceived . . . . .	710	
		<hr/>
Total requests received . . . . .		4,444
Number of rejected claims . . . . .		437
Claims sent to welfare . . . . .		29,776

**HEADQUARTERS OFFICE**

The Headquarters Office has functioned well and has been most cooperative due to the foresight and excellent judgment of the Executive Staff. Mr. Milton Krueger, the Executive Secretary, Mr. Jim Moffett, the Assistant Executive Secretary and Mrs. Catherine Wooten, Assistant Executive Secretary have been most most cooperative and deserve commendation for service beyond the call of duty.

**HEADQUARTERS OFFICE BUILDING**

The Headquarters Office Building has been used on numerous occasions as a meeting place for MAG and allied organizations. During the year the city and county tax assessors have required the Medical Associa-



tion to begin paying property taxes. This will amount to approximately \$3,000.00 a year additional expenses to the Association. No major repairs have been necessary during the past year, however, it is anticipated that interior painting and cleaning will be required during the year in order to maintain the Headquarters Building in a proper state of repair.

MAG MEMBERSHIP

	1965	1964
Active .....	2,925	2,841
Active dues exempt .....	316	325
Service members .....	65	59
Associate .....	45	35
Total .....	3,351	3,260

I wish to express my appreciation to my many friends and associates for the privilege of serving you as Secretary for the past six years.

REFERENCE COMMITTEE RECOMMENDATION—The Committee recommends approval with commendation and with the following recommendation; that a field service representative be employed by MAG in order to establish better relationships among the component societies, and that this be done as soon as funds can be made available.

HOUSE OF DELEGATES ACTION—Adopted the report of the Secretary with the additional recommendation made by the Reference Committee on motion duly made and seconded.

Treasurer

JOHN S. ATWATER, M.D., Atlanta

The report of the auditors, Ernst and Ernst, is attached. This audit covers the period ending the calendar year December 31, 1965. It is to be pointed out that

the Association remains in good financial condition. While the overhead expenses have increased there has also been an increase in income sufficient to meet these obligations.

I should like to thank most sincerely all those who have had a part in the conduct of the office of the Treasurer, especially our most efficient bookkeeper, Miss Thelma Franklin.

ERNST & ERNST  
FIRST NATIONAL BANK BUILDING  
ATLANTA, GA. 30303

Chairman of the Council  
The Medical Association of Georgia  
Atlanta, Georgia

We have examined the statement of assets and liabilities of the several funds of The Medical Association of Georgia as of December 31, 1965, and the related statements of income and expenses and fund equities for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. While it was not practicable to confirm the amount due from the United States Government with respect to the Medicare Fund, we have satisfied ourselves as to this balance by means of other auditing procedures.

In our opinion, the accompanying statement of assets and liabilities and the statements of income and expenses and fund equities present fairly the financial position of the several funds of The Medical Association of Georgia at December 31, 1965, and the results of their operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

*Ernst & Ernst*

Atlanta, Georgia  
February 21, 1966

STATEMENTS OF ASSETS AND LIABILITIES—BY FUNDS

The Medical Association of Georgia  
December 31, 1965

ASSETS

GENERAL FUND

Cash:			
Demand deposits .....		\$ 9,671.85	
Savings deposits:			
Restricted .....	\$11,748.85		
Unrestricted .....	70,000.00	81,748.85	\$ 91,420.70
Accounts receivable:			
Advertisers of The Journal .....		\$ 4,792.04	
Due from Old Age Assistance Program .....		1,481.11	6,273.15
Other assets .....			625.00
Property and equipment—on the basis of cost:			
Buildings—mortgaged .....		\$ 94,454.72	
Furniture and equipment .....		26,242.27	
		\$120,696.99	
Less allowances for depreciation .....		51,519.58	
		\$ 69,177.41	
Land—mortgaged .....		80,000.00	149,177.41
			\$247,496.26



## ABNER W. CALHOUN LECTURESHIP FUND

Cash .....	\$ 139.46	
Corporation stocks (quoted market prices \$5,460.50)—at cost ..	5,897.03	6,036.49

## MEDICARE FUND—DEPARTMENT OF THE ARMY

Cash .....	\$ 22,216.65	
Due from United States Government—service fees paid to physicians and dentists .....	77,783.35	100,000.00
		<u>\$353,532.75</u>

## LIABILITIES AND EQUITIES

### GENERAL FUND

#### Liabilities:

Note payable to insurance company, \$4,000.00 installment, with interest at 5%, due on January 1, each year—secured by loan deed on land and building .....		\$ 11,000.00
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Excess of claim fees received over claim expenses—United States Government—Medicare .....		2,511.16
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#### Advance collections:

1966 membership dues .....	\$ 1,820.50	
1966 exhibit space payments .....	3,412.50	5,233.00

#### Fund equity:

##### Restricted:

Regular operating purposes .....	\$ 20,000.00	
Lecture expenses .....	156.67	

	<u>\$ 20,156.67</u>	
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Unrestricted .....	208,595.43	228,752.10
		<u>\$247,496.26</u>

### ABNER W. CALHOUN LECTURESHIP FUND EQUITY

6,036.49

### MEDICARE FUND—DEPARTMENT OF THE ARMY

Advance from United States Government .....	100,000.00
	<u>\$353,532.75</u>

## STATEMENT OF FUND EQUITIES

The Medical Association of Georgia  
Year ended December 31, 1965

	Balance Jan. 1, 1965	Extraordinary Legal Fees	Adjusted Balance Jan. 1, 1965	Income in Excess of Expenses	Fund Transfers	Balance Dec. 31, 1965
<b>GENERAL FUND</b>						
Restricted for operating purposes	\$ 20,000.00	\$ -0-	\$ 20,000.00	\$ -0-	\$ -0-	\$ 20,000.00
Restricted for lecture expenses	412.15	-0-	412.15	-0-	255.48*	156.67
Unrestricted .....	201,444.84	3,135.00(A)	198,309.84	10,285.59	255.48*	208,595.43
	<u>\$221,856.99</u>	<u>\$3,135.00</u>	<u>\$218,721.99</u>	<u>\$10,285.59</u>	<u>\$255.48*</u>	<u>\$228,752.10</u>
<b>ABNER W. CALHOUN LECTURESHIP FUND</b>						
	6,032.99	-0-	6,032.99	251.98*	255.48	6,036.49
TOTAL	<u>\$227,889.98</u>	<u>\$3,135.00</u>	<u>\$224,754.98</u>	<u>\$10,033.61</u>	<u>\$ -0-</u>	<u>\$234,788.59</u>

\* Indicates red figure.

(A) During 1964 the Association settled previously contested assessments for ad valorem taxes for the years 1960 through 1964. Legal fees applicable to this litigation were charged to the unrestricted portion of the General Fund Equity as of January 1, 1965.



# STATEMENT OF INCOME AND EXPENSES—BY FUNDS

The Medical Association of Georgia  
Year ended December 31, 1965

Abner W.  
Calhoun  
Lectureship  
Fund

## INCOME

	General Fund	
Medical Association of Georgia dues .....	\$117,047.50	\$ -0-
Advertising—The Journal .....	34,171.09	-0-
Subscriptions—The Journal .....	1,018.57	-0-
Exhibitors fees—1965 annual meeting .....	8,225.00	-0-
Interest income .....	4,748.69	-0-
Dividends—corporate stocks .....	-0-	271.42
American Medical Association refund .....	1,274.17	-0-
Miscellaneous .....	410.68	-0-
<b>TOTAL INCOME</b>	<b>\$166,895.70</b>	<b>\$271.42</b>

## EXPENSES

Fixed allotments .....	\$ 7,982.40	\$ -0-
Association office—Note .....	86,372.56	-0-
Association boards .....	12,604.33	-0-
Related Association activities .....	1,295.38	-0-
Contingent fund .....	5,026.86	-0-
The Journal .....	43,328.58	-0-
Trustees fees and expenses .....	-0-	23.40
Lecture expenses .....	-0-	500.00
<b>TOTAL EXPENSES</b>	<b>\$156,610.11</b>	<b>\$523.40</b>
<b>EXCESS (DEFICIENCY*) OF INCOME OVER EXPENSES</b>	<b>\$ 10,285.59</b>	<b>\$251.98*</b>

See Note to Statement of Fund Equities.

\* Indicates red figure.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee recommends approval with commendation. A typographical error in the Delegate's Handbook was corrected by the Treasurer.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Treasurer as recommended by the Reference Committee on motion duly made and seconded.

## Speaker, House of Delegates

J. FRANK WALKER, M.D., Atlanta

The annual report of the Speaker of the Medical Association of Georgia House of Delegates begins with a brief résumé of the Association activities on the actions of the 1965 Session of the MAG House.

Forty-seven separate actions were taken by the MAG House of Delegates, meeting May 4, 1965, as published in the Proceedings of the House, *Journal of the Medical Association of Georgia*, June issue 1965. These actions were presented to the MAG Council for implementation during the Association year 1965-66. It was my privilege as Speaker to follow-through on the actions to see that they were completed according to the intent of the House. I am very pleased to report that all of these actions have been completed, or are well along in the process of completion or continuing action by the Council, its Executive Committee, or by referral of Council to the appropriate MAG Board or Subcommittee. I strongly believe that, in addition to the duties as presiding officer at sessions of our House of Delegates, it is most important for the Speaker to see that the wishes of the House are carried out during the ensuing year in behalf of the House. A monthly check

of progress on the items is the most effective way to follow through on their implementation and I recommend this system be continued in the interest of carrying out the policies set by the House.

I wish to report that we have again "streamlined" the procedures for the Annual Session of the House of Delegates. Traditionally, the House has held its "introduction of business" meeting on Monday morning of the MAG Annual Session, followed by the meeting of House Reference Committees on Monday afternoon. We then have convened the "voting" session of the House the next day on Tuesday afternoon. Because we have noted a drop in attendance at the Tuesday afternoon meeting of the House, we have closed the gap between these two meetings in hopes that Delegates to the House will remain for the second "voting" session of the House. Our 1966 schedule of meetings of the House is set so that the first session will be held Monday morning, followed by Reference Committee meetings Monday afternoon, as was previously done. Our second session of the House will be held Tuesday morning rather than Tuesday afternoon. By closing this gap between the Monday and Tuesday meetings of the House, we may be able to increase the "stay-over" attendance at our second "voting" session of the House. Dependent on how this innovation works out, I would appreciate the expressed feeling of the House on this matter.

Many members of the House requested that the House Reference Committees meet in separate rooms, rather than in areas of the same meeting room as we did at the 1965 House meeting in Augusta. Arrangements have been made, per your House of Delegates Handbook listing, for separate meeting rooms for our Ref-



erence Committees. As directed by a 1965 action of the House, a special Reference Committee (Reference Committee No. 6) has been set up for this 1966 session to handle solely the report of the MAG Fee Schedule Negotiating Committee which was created by the 1965 House.

Your Speakers have attended the meetings of MAG Council and other meetings of the Association as is necessary for the Speakers to attend. I extend my appreciation to Harrison Rogers, who has fulfilled his duties as Vice Speaker in an exemplary manner.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee recommends approval with commendation and also recommends that the streamlined program for the House of Delegates be continued if it proves to be effective in increasing the number of Delegates at the Second Session.

We commend the clerical staff of MAG for the necessary extra effort in making this possible.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Speaker of the House of Delegates with the additional recommendation made by the Reference Committee on motion duly made and seconded.

Vice Speaker, House of Delegates

HARRISON L. ROGERS, JR., M.D., *Atlanta*

The duty of the Vice Speaker is to support and assist the Speaker in seeing that the decisions of the House of Delegates are implemented. In view of the exceptional record of implementation this year described in the report of the Speaker, this office's duties have been few.

Subsequent to the submission of this report, the Vice Speaker will assist in the delegation of matters for consideration by the House of Delegates to the respective reference committees. Every attempt will be made to distribute the work load equitably.

**REFERENCE COMMITTEE RECOMMENDATION**—This Committee recommends approval.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Vice Speaker of the House of Delegates as recommended by the Reference Committee on motion duly made and seconded.

Fifth District Councilor

FLOYD R. SANDERS, JR., M.D., *Decatur*

Another year of medical progress and dedicated service to the citizens of the Fifth District has been put in the record by members of the constituent medical societies—Fulton County and DeKalb County.

The notable activities of Fulton County Medical Society will be covered by its Councilor.

DeKalb County Medical Society continues to represent organized medicine in a creditable fashion in civic activities and responsibilities as well as carrying the major load of medical care for citizens of the county. DeKalb General Hospital continues to share in a major portion of the medical responsibilities. Efforts are still being made to find some ways to unravel State and Federal red tape in order to get the much needed expansion to 400 beds under way.

The Fifth District Medical Society met for its annual meeting on November 4, 1965, at which time a program on "Implementation of Hospital and Medical Benefits under Medicare" was presented by Mr. Harris Berman from the Social Security Administration in Baltimore,

Maryland. The meeting was presided over by the outgoing President, Dr. Carl C. Jones, Jr. New officers were elected as follows: Floyd R. Sanders, Jr., President; Chenault W. Hailey, Vice President; and Paul Teplis continues as Secretary-Treasurer for another year.

It has been my pleasure to attend all meetings of Council during the past year, and the able support of the Vice Councilor, Dr. M. F. Simmons has been invaluable and very much appreciated. We were privileged to host the September meeting of Council at Stone Mountain Memorial Park.

Counties and Secretaries	Members		Members	
	December 31, 1965		December 31, 1964	
	MAG	AMA	MAG	AMA
DeKalb	Dues Paying Only		Dues Paying Only	
Catherine E. Foster				
Decatur	159	147	153	138

**REFERENCE COMMITTEE RECOMMENDATION**—This Committee recommends approval.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Fifth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fulton County Councilor

CHARLES S. JONES, M.D., *Atlanta*

The activity of Council, and much of the thought of the Councilors during the past several months has been influenced and focused on the matter of the pending Medicare program. The problems of this program are both complex and widespread. The shortages and dire situations which have been predicted are in fact not really known. How many people over sixty-five have gotten inadequate medical care? How many people in this age group will come rushing to the doctors and hospitals requesting medical care after the first day of July 1966, is largely a matter of guesswork at this time. There is no question but what there will be an increased demand for medical services, hospital services and extended care beyond the hospital. An accurate appraisal of the amount of additional work that will be required in these categories is still unknown.

Under the Medicare law it will be a requirement of physicians to serve on hospital Utilization Committees. These committees will have various functions and the exact requirements under the law have not yet been clearly outlined. The objective of such committees is to improve the efficiency of the hospital and minimize the possibility of unnecessary admissions and overstay on the part of patients. Just how this is to be accomplished in individual situations has not yet been ascertained.

Under the Supplementary Medical Section of the Medicare Law, Insurance Review Committees on a county or regional basis will play a vital role in assisting the insurance carriers administer the Supplementary Medical Section of the Medicare Law. There has been much discussion concerning fees. No one knows how this will be resolved. The general guideline which has been outlined is that the doctor will charge fees which he would normally have charged under similar circumstances in the absence of Medicare. Such a broad statement does not answer all of the situations which can occur, and certainly does not answer new situations which will arise under this government supported program.

During the past year the Council of the Medical Association of Georgia has been involved in many detailed



matters of conducting the affairs of medicine in our State. Committees have worked diligently to revise and re-formulate certain sections of our Constitution and Bylaws. The activity of the Medical Association in assisting in the administration of the Kerr-Mills Program has also been diligently pursued and has been done quite well. Just how these activities will be fitted into the broad scale of government participation in medicine has not yet been ascertained.

This Councilor will terminate a period of some twelve years of duty as Councilor from the Fifth District and the Fulton County Medical Society with our Annual Session in May. Few things have given me as much pleasure, given me such abundant opportunities to serve my fellow doctors in their efforts to provide health care for our communities. In the period of time in which I have served on Council, there has been a constant direction of increasing complexities in the paramedical affair. Medical politics, medical economics, health insurance and now government participation in medical care, all will contribute to make the life of each doctor somewhat more complex than in past years. However, I remain optimistic in the belief that the final responsibility for health care will remain with the doctors if we accept the responsibility and aggressively pursue reasonable courses of action. I am hopeful that we will not have the total domination of medicine by government which has occurred in so many other countries of the civilized world.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Fulton				
W. W. Moore				
Atlanta	1,070	877	1,039	852

Late Report No. 2

FULTON COUNTY COUNCILOR

LINTON H. BISHOP, *Atlanta*

The past year has been a time of growth and reassessment for the Fulton County Medical Society. The Society is now a district of its own, and is separate in district operations from the DeKalb County Medical Society with which we have enjoyed a very favorable relationship in the past.

I regret to report that Dr. Charles Jones did not offer for re-election as a Fulton County Councilor after many years of dedicated, diligent and effective service. I would like to commend Dr. Jones for his efforts in the past on behalf of the Society. We are fortunate in having two new Councilors appointed by Fulton County for the coming year. Dr. Fleming Jolley and Dr. Harold Harrison will offer valuable additions to our deliberations.

We are in full agreement with the position of the AMA and the Medical Association of Georgia in striving for a usual and customary fee program when third party payment is involved. An effective insurance committee must be set up by each local unit to prevent abuses under this concept.

I participated in the Medical Leadership Conference in Atlanta, in February, and I am happy to report that Fulton County was well represented and that our physicians received much valuable information and stimulation from this Conference. This Councilor has been

active in the deliberations of Council in the past year and I will continue to serve as best I can during the coming year.

Fulton County Vice Councilor

FLEMING L. JOLLEY, M.D., *Atlanta*

This Vice Councilor has attended all Council meetings of the past year. This was my first year to attend and there has been an enlightening, informative experience. I believe MAG Delegates and county society officers would find the time well worth the effort to attend those meetings held in their area.

Last year in Augusta, your past president, Dr. J. G. McDaniel, amplified the need of medical evaluations in driver licensures. Each year the increased number of traffic accidents with deaths and injuries supports this known basic requirement. Many States have already advanced in this field. A more aggressive effort is needed in Georgia. Ground work has been established with the introduction of driver training courses in the most recent Legislature.

I would recommend that a MAG Committee be established to take an active role with county society traffic safety committees, the State Board of Health, and responsible legislative groups, and insuring agencies to further establish laws that can reduce the needless highway slaughters.

REFERENCE COMMITTEE RECOMMENDATION—The Fulton County Medical Society Councilors and Vice Councilor were considered together. The report by Dr. Charles Jones: The Committee recommends approval with commendation and also expresses regrets for his resignation. The report by Councilor Linton Bishop: The Committee recommends approval. The report by Vice Councilor Fleming Jolley: The Committee recommends approval with commendation and recommends that MAG establish a standing committee on Traffic Safety and that component societies be encouraged to have a similar committee.

HOUSE OF DELEGATES ACTION—Adopted the reports the Fulton County Medical Society Councilor, Dr. Charles Jones; the Fulton County Medical Society Councilor, Linton Bishop; and the Fulton County Medical Society Vice Councilor, Fleming Jolley, with the additional recommendations made by the Reference Committee on motion duly made and seconded.

Sixth District Councilor

WILLIAM RAWLINGS, M.D., *Sandersville*

The Sixth District Medical Society has had regular meetings during this year, and these have been well attended. Since this District is being disrupted as much or more than any of the other Districts, the county societies involved are already affiliating themselves with their new District and looking forward to a close relationship and cooperation in the future.

This Councilor will no longer reside in the Sixth District and has been nominated as Vice Councilor for the Tenth District in which capacity he will continue to serve.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Baldwin				
A. C. Martinez				
Milledgeville	30	26	29	24
Jasper				
E. M. Lancaster				
Shady Dale	3	3	4	4



Jefferson				
Walter J. Revell				
Louisville	5	4	5	4
Laurens				
Ridley M. Glover				
Dublin	36	16	34	15
Washington				
Dean L. Holmes				
Sandersville	13	6	13	6
	87	55	85	53

REFERENCE COMMITTEE RECOMMENDATION—The Committee recommends approval.

HOUSE OF DELEGATES ACTION—Adopted the report of the Sixth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

### Bibb County Councilor

WM. H. M. WEAVER, M.D., *Macon*

The Bibb County Medical Society during 1965 made an effort to have better contact with the local lawyers, pharmacists and ministers. It was felt that through better understanding all would benefit, and we hoped the patient would benefit most of all. Committees have been established to further these goals.

Also during 1965 the Bibb County Medical Society went on record for and encouraged the erection of more hospital beds in The Middle Georgia Hospital.

All Council meetings were attended by either the Councilor or Vice Councilor for Bibb County.

At present the Bibb County Medical Society has 183 members of the MAG and 160 members of AMA. In 1964 there were 174 MAG members and 158 AMA members.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Bibb				
John T. DuPree				
Macon . . . . .	183	160	174	158

### Bibb County Vice Councilor

BRASWELL COLLINS, M.D., *Macon*

The Bibb County Medical Society had representation at a "reorganizational" District meeting in Griffin, February 9, which was called by Dr. Virgil Williams of Griffin.

This Society has voted unanimously to secure membership in the new Sixth District Medical Society. Dr. James Lawrence of the Bibb County Medical Society is the elected secretary for the "new" Sixth District Medical Society. An added attraction of the Sixth District is that it includes "Callaway Gardens."

Our local Medical Society has had a successful year under the leadership of Dr. Earl Lewis. A new year of success and progress is anticipated under the leadership of Dr. Hugh Sealy. The re-elected secretary is Dr. John DuPree.

REFERENCE COMMITTEE RECOMMENDATION—Report by William Weaver: The Committee recommends approval with commendation, and recommends that all component societies be encouraged to establish better inter-professional relationships unless they have already established such programs.

HOUSE OF DELEGATES ACTION—Adopted the report of the Bibb County Medical Society Councilor and the Bibb County Medical Society Vice Councilor with the additional recommendation made by the Reference Committee on motion duly made and seconded.

### Rural Health Subcommittee

T. N. LUMSDEN, M.D., *Chairman*

Report of activities of the Subcommittee on Rural Health of the Medical Association of Georgia for the year 1965:

Year 1965 was a fairly active one for the Subcommittee on Rural Health of the Medical Association of Georgia. At one of the first meetings, held at the MAG Headquarters, it was decided by the membership to sponsor a Rural Health Conference for the State of Georgia. Such conferences have been held on a National and Regional level for a number of years and a good many states have sponsored these but this was the first effort along this line which had been made in Georgia. Since this was to be a premier performance it was felt advisable to seek some aid and advice in this field. Accordingly, Dr. Bond Bible, Executive Secretary of AMA Counsel on Rural Health, was invited to attend the planning conference with the members of the Subcommittee on Rural Health. In addition to Dr. Bible, Miss Lucille Higginbotham representing the Agriculture Extension Service of the University of Georgia was also invited to attend. A proposed agenda for the Conference was outlined and a tentative site for holding the Conference was agreed upon. It was decided that this Conference would be held at the Rock Eagle 4-H Conference Ground near Eatonton, Georgia and that it would extend over a portion of two days. Following this a meeting was held with the leaders of the Women's Division of the Georgia Farm Bureau and the proposed program was presented to them for their approval. This also was presented to the President of the Georgia Farm Bureau and was received with enthusiasm by both the President and the representatives of the Women's Division. Dates for the conference were then arranged with the Director of the Rock Eagle State Park and speakers were contacted for the program. The Conference was held on the 22nd and 23rd of October with more than 100 people in attendance. Represented were the Georgia Farm Bureau, Home Demonstration Clubs, County Agents Groups, County Home Demonstration Agents, PTA, Georgia Heart Association, The Georgia Academy of General Practice, and the Georgia Mental Health Association.

It was felt that this conference was extremely well received. Members from the Farm Bureau were particularly grateful for the interest shown in them and seemed most eager to have this conference repeated. Even though a considerable amount of leg work and effort was expended in the planning and execution of this conference it was felt that the effort was well worthwhile, because of the interest generated in MAG activities throughout the Georgia Farm Bureau. Representatives from the Georgia Farm Bureau and MAG have worked together on many legislative programs in the past and it is felt that efforts to keep this relationship alive and thriving are justifiable.

As a follow up to this, members of the staff of MAG and the staff of the Georgia Farm Bureau have met and discussed mutual problems of interest and one request has been voiced to MAG from the Farm Bureau, re-



questing liaison on county level between the local societies and County Farm Bureaus. It is the intention of the Rural Health Committee to help to foster this program. Accordingly during the coming year requests will be made to physicians to serve as liaison agents between the local societies and County Farm Bureaus. It is sincerely requested that members of the MAG participate in this program actively and cooperate with it to the fullest of their extent when called upon. In view of the benefits to accrue to both MAG and the Farm Bureau from such a closer working relationship it is felt that this program deserves all the support which it can be given.

In addition to the above program which received major emphasis, MAG was represented at the National Rural Health Conference which was held in Miami in April of last year by the Chairman of the Subcommittee on Rural Health. This Committee provided judges for the 4-H Health Project at the time of the Annual 4-H Congress held in Atlanta in August. The Chairman of this Subcommittee was invited to speak at the annual meeting of the Georgia Farm Bureau which was held at Jekyll Island in November.

In projecting plans for 1966 one of the prime areas for work will be the planning and production of a second Rural Health Conference for the state since the first one appeared to fill a real need. In addition, the providing of liaison agents as outlined above will be promoted. Cooperation with the Agriculture Extension Service and work with the 4-H groups will continue. MAG will again be represented at the National Rural Health Conference which will be held in Colorado Springs in March.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee recommends approval with highest commendation. We also recommend that better liaison be established between all component societies, Farm Bureaus, and other rural agencies in order to improve health services and public relations.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Rural Health Subcommittee with the additional recommendation made by the Reference Committee on motion duly made and seconded.

## Late Report No. 4

### PROFESSIONAL CONDUCT COMMITTEE

MILFORD B. HATCHER, *Chairman*

For some time I have waited to send my reports as regards the Professional Medical Ethics Committee and the Hospital Relations Board, thinking that there may be something that would come out as regards legislation that has been introduced and clarification regarding the Utilization Committee.

I would like to include then as my report for the Professional Medical Ethics Committee that there has not been any violation of medical ethics presented to this committee this year.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee recommends approval.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Professional Conduct Committee as recommended by the Reference Committee on motion duly made and seconded.

## Late Report No. 5

### HOSPITAL ACTIVITIES BOARD

MILFORD B. HATCHER, *Chairman*

In regard to the Hospital Relations Board, I would like to submit that there is a considerable amount of confusion and impending legislation regarding hospital responsibilities under the impending Medicare Program. At the present time there is not any clarification; therefore, I do not feel that we can make any recommendations.

There are a considerable number of ancillary personnel training bills before Congress. The exact outcome and relation to hospitals can not be given at the present time; therefore, no recommendations are made as regards the impending legislation.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee recommends approval.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Hospital Activities Board as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Reference Committee No. 1 Chairman Alex Jones, Griffin, and duly seconded that the report of the Reference Committee be approved as a whole, and it was so ordered.

## Report of Reference Committee No. 2

Henry Scoggins, Augusta, *Chairman*

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)*

Reference Committee No. 2 of the 1966 Annual Meeting of the Medical Association of Georgia met in the Green Room, Ralston Motor Hotel, 2:30 p.m., Monday, May 9, 1966.

The following members of Reference Committee No. 2 were present: Henry Scoggins, M.D., Augusta, Chairman; William G. Sutlive, M.D., Savannah, Vice Chairman; H. Hilt Hammett, Jr., M.D., LaGrange, Secretary; Albert A. Rayle, Jr., M.D., Atlanta; John D. Deal, M.D., Statesboro; John H. Robinson, III, M.D., Americus; and Clyde C. Harrison, Jr., M.D., Forest Park.

## Council of MAG

CHARLES R. ANDREWS, M.D., *Chairman*

Council has met according to schedule, having its organizational meeting immediately following the Annual Convention in Augusta. The first regular Council meeting in June held in Third District at Cordele. Second regular meeting held in Fourth District at Stone Mountain. Third meeting in December in Eighth District at Valdosta. Fourth meeting in Eighth District at Jekyll Island. At the time of preparing this report the final meeting of Council for 1965-66 will be held immediately prior to the State Convention in Columbus.

The House of Delegates designated a number of activities for MAG which were to be implemented by



Council. The following are subjects and action taken on them by Council:

1. MAG President's honorarium adjusted from \$1,000 to \$2,400 per annum by the Finance Committee and approved by Council.
2. Support of GaMPAC by MAG was accomplished via direct action of the Council.
3. Activity in the field of ethics is being carried out per directions of the House. A special Ad Hoc Committee on Medical Ethics was appointed by Council and this Committee is working.
4. Redistricting of Councilor Districts as recommended by the House has been carried out.
5. A relative value study was made available to the Fee Schedule Negotiating Committee which was created by the House in 1965.
6. The Georgia Hospital-Medical Council personnel situation was studied and it was determined that an increase in staff was not required.
7. MAG representation in socio-economic matters has been carried out by the Council through the Legislative Board.
8. A committee to investigate the possibility of having a physician appointed to all Area-Wide Planning Committees was created and a program to inform component county medical societies of this matter has been carried out.
9. The Speaker of the House, in behalf of the House, expressed condolences to Governor Sander's family on the death of the Governor's father.
10. At all Council meetings, Delegates from counties in the vicinity of such meetings have been invited to attend.
11. County Medical Societies have been requested to make certain that their Delegates attend all meetings of the House of Delegates.
12. A resolution on "Fireproofing for Clothing" approved by the 1965 House of Delegates was submitted by MAG Delegates to the AMA.
13. MAG Headquarters Office dues statements were altered to provide for the simultaneous collection of GaMPAC dues.
14. Albert C. Tuck, D.D.S., Thomasville, was made an affiliate member of the MAG at request of the House.
15. MAG Constitution and Bylaws changed to permit an MAG Past President to serve on Council for three years following his Presidential year.
16. A resolution commending the AMA for its efforts to defeat "medicare" was submitted to AMA by MAG Delegates.
17. A letter of commendation to Dr. Eustace Allen for his service to the profession was written as per instructions from the House.
18. A letter of commendation to Dr. Rhodes Haverty was written for his service as Chairman of the weekly health column committee.
19. The merger of the Warren County Medical Society was accomplished.
20. Efforts to improve the Tenth District Medical Society meetings were made through the cooperative efforts of the Councilor, Vice Councilor, President and Secretary of District Society.
21. A resolution concerning the adoption of "medical staff letterhead" was submitted by MAG Delegates to the AMA as per instructions of the House.
22. A resolution concerning the "separation of hospital charges and professional fee in radiologic services"

was submitted by MAG Delegates to the AMA.

23. This same resolution was sent to the Georgia Radiological Society membership, all hospital administrators and all hospital Chiefs of Staff in Georgia.

24. Annual Session program changes have been implemented as recommended by the House of Delegates.

25. Letters of appreciation were written to members of the Georgia Delegation in the Congress who supported the profession's stand on "medicare."

26. County Medical Societies were informed to emphasize to their members the need to promote good emergency room coverage in local hospitals as directed by the House.

27. County Medical Societies were informed that if they wished to bill for Auxiliary dues along with their own membership dues that it would be a matter of local determination.

28. A request for legislation authorizing the State of Georgia to re-examine all over age 55 applicants for a drivers license was referred to the Legislative Board.

29. A voluntary sterilization bill was submitted to the General Assembly through the Legislative Board as requested by the House.

30. Legislation requesting a mandatory three day waiting period on the issuance of all marriage licenses was referred to the Legislative Board.

31. The MAG Medical Education Conference to become an every-other-year event beginning in 1967.

32. The Council appointed a Paramedical Recruitment and Education Committee to implement the recommendations of the House on this matter. County Medical Societies requested to hold at least one meeting of Society each year on the subject of medical ethics.

33. The Medical Education Board and the Legislative Board took action to increase the supply of paramedical personnel.

34. MAG cooperated with appropriate State agencies in recommendations for the transfer of nonpsychotic elderly patients from Milledgeville State Hospital to nursing homes.

35. Several matters of concern in the area of medical education were referred to the Medical Education Board and implemented.

36. The MAG House of Delegates position on local mental health programs was disseminated to appropriate groups by the Mental Health Subcommittee.

37. The Council has cooperated with the Woman's Auxiliary to MAG on the recommendations made by the Auxiliary and adopted by the House last year.

38. The MAG Insurance and Economics Board has made many efforts in behalf of securing better and increased mental health insurance coverage.

39. Recommendations concerning compulsory student physical education were referred to the Subcommittee on School Child Health for liaison and possible implementation with the State Department of Education.

The members of Council are to be greatly commended for the manner in which they have facilitated the conduction of the Council meetings. As may be readily recognized, Council has had many decisions to make with quite a large work load and many controversial subjects.

Proposed changes to the MAG Constitution and Bylaws were submitted to and reviewed by the Council as is required by the Constitution and Bylaws. The ac-



tion taken by the Council on each change proposed by the Constitution and Bylaws Board will be found as a part of the report given by the Constitution and Bylaws Board. The report of this Board is found elsewhere in this Handbook.

**REFERENCE COMMITTEE RECOMMENDATION—**This report of Council of MAG was received with approval and commendation. This Reference Committee desires to sincerely express to Charles R. Andrews, M.D., Chairman of Council, our special appreciation for his excellent and dedicated leadership.

**HOUSE OF DELEGATES ACTION—**Adopted the report of the Council of MAG with the additional recommendation made by the Reference Committee on motion duly made and seconded.

**First District Councilor**

CHARLES E. BOHLER, M.D., *Brooklet*

As First District Councilor, I have attended all scheduled and called meetings of Council during the past year.

The First District Medical Society meeting was held April 13, in Statesboro.

We welcome the Laurens County Medical Society into the First District.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG Dues Paying Only	AMA	MAG Dues Paying Only	AMA
Bulloch-Candler-Evans				
C. E. Bohler				
Brooklet . . . . .	14	14	17	16
Burke				
C. G. Green				
Waynesboro . . . . .	8	5	8	6
Emanuel				
R. G. Brown				
Swainsboro . . . . .	9	8	7	6
Jenkins				
A. P. Mulkey				
Millen . . . . .	3	3	3	3
Screven				
W. G. Simmons				
Sylvania . . . . .	5	5	5	5
Southeast Georgia				
Travis Nobles				
Lyons . . . . .	28	20	29	22
Tri-Liberty-Long-McIntosh				
O. D. Middleton				
Ludowici . . . . .	3	2	5	3
	70	57	74	61

**REFERENCE COMMITTEE RECOMMENDATION—**This report was accepted and approved.

**HOUSE OF DELEGATES ACTION—**Adopted the report of the First District Councilor as recommended by the Reference Committee on motion duly made and seconded.

**Georgia Medical Society Councilor**

T. A. PETERSON, M.D., *Savannah*

The following is my report as Councilor for the Georgia Medical Society to the Medical Association of Georgia:

As of December 31, 1965, we had a total of 158 members of the Medical Association of Georgia and a total of 140 dues paid members. As of December 31, 1964, we had a total membership of 158 and a total of 142 dues paying members.

There has been nothing unusual to occur that would justify including in this report for the past year.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG Dues Paying Only	AMA	MAG Dues Paying Only	AMA
Georgia Medical Society				
J. J. Holloman				
Savannah . . . . .	158	140	158	142

**Georgia Medical Society Vice Councilor**

JOHN KIRK TRAIN, M.D., *Savannah*

As Vice Councilor of the Georgia Medical Society during the past year I have been unable to attend a few of the meetings, but have enjoyed the ones I have attended which have been most instructive also. I have worked with the Councilor, Dr. T. A. Peterson and the President-Elect of MAG, Dr. Walter Brown to bring back to our local meetings important events that have transpired at the Council meetings.

**REFERENCE COMMITTEE RECOMMENDATION—**The reports of the Georgia Medical Society Councilor and Georgia Medical Society Vice Councilor were accepted and approved.

**HOUSE OF DELEGATES ACTION—**Adopted the reports of the Georgia Medical Society Councilor and the Georgia Medical Society Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

**Second District Councilor**

W. F. MCKEMIE, M.D., *Albany*

As Councilor of Second District, I wish to report attendance at all regular meetings of Council during the past year except one which I was absent due to illness of a close relative.

Medical Seminars or Symposia were given by Dougherty County Medical Society and Thomas County Medical Society during the year and were well attended. Colquitt County Medical Society cooperated with the Medical College of Georgia in Medical Symposia held in that locality.

Membership in both the Medical Association of Georgia and American Medical Association has increased in the district during the past year, attesting to the growth of the profession in the District.

As requested in information letters supplied by the Medical Association of Georgia, I am forwarding a letter of resignation as Councilor for Second District to Dr. H. G. Davis, Jr., President of the Second District Medical Society in order that the newly constituted District may nominate a Councilor to the Annual Session of Medical Association of Georgia.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG Dues Paying Only	AMA	MAG Dues Paying Only	AMA
Colquitt				
W. E. Harrison				
Moultrie . . . . .	17	16	17	16
Decatur-Seminole				
M. A. Ehrlich				
Bainbridge . . . . .	15	12	16	14
Dougherty				
A. M. Freeman, Jr.				
Albany . . . . .	58	46	56	44
Grady				
S. L. Hancock				
Cairo . . . . .	5	5	5	5



Mitchell				
A. A. McNeill, Jr.				
Camilla	9	8	8	8
Southwest Georgia				
W. D. Reynolds, Jr.				
Edison	14	12	11	10
Thomas-Brooks				
Julian B. Neel				
Thomasville	42	39	43	38
Tift				
J. F. Kirkpatrick, Jr.				
Tifton	18	13	15	10
Worth				
W. P. Stoner				
Sylvester	5	5	5	5
	<hr/> 183	<hr/> 156	<hr/> 176	<hr/> 150

Second District Vice Councilor

JAMES C. BRIM, M.D., *Pelham*

It has been my pleasure to serve as Vice Councilor for the Second District Medical Society for the past three years. The Vice Councilor has attended all but two Second District Medical Society Meetings, and co-operating with the Councilor of the Second District, we have been trying to bring to the physicians of our District all pertinent information pertaining to legislation and relaying to them decisions from the Council which would increase the Council Society's effectiveness. The Vice Councilor has distributed to all county Society members and to the Second District Medical Society officer the booklet, Judicial Council Opinions and Reports. Efforts are being made to get a good attendance at the State meeting.

REFERENCE COMMITTEE RECOMMENDATION—The reports of the Second District Councilor and the Second District Vice Councilor were accepted and approved.

HOUSE OF DELEGATES ACTION—Adopted the reports of the Second District Councilor and the Second District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Third District Councilor

FRANK A. WILSON, M.D., *Leslie*

Activity in the Third District has been less than usual, pending completion of reorganization. There are only four medical societies completely within the District. Of the split societies, Flint has continued active and has voted to organize with this District.

The fall meeting of the societies was held in Cordele, with Flint Society as host. The spring meeting will be held in Americus on April 14, with Sumter Society as host. It is hoped that the activity of the District Society can be improved, following completion of the reorganization this year.

As Councilor for the Third District, I have attended all of the regular and call meetings of the Council.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Ben Hill-Irwin				
Ralph Roberts				
Fitzgerald	9	8	10	9
Flint				
C. C. Goss				
Ashburn	14	12	15	13

Peach Belt				
Harry E. Sims				
Fort Valley	35	30	35	30
Ocmulgee				
Ray L. Johnson				
Eastman	16	11	15	10
Randolph-Terrell				
Carl E. Sills				
Cuthbert	13	11	13	11
Sumter				
Harvey Simpson				
Americus	21	17	21	17
Taylor				
E. C. Whatley				
Reynolds	3	2	3	2
	<hr/> 111	<hr/> 91	<hr/> 112	<hr/> 92

Late Report No. 1

THIRD DISTRICT VICE COUNCILOR

JOSEPH T. CHRISTMAS, *Vienna*

The Vice Councilor for the Third District attended all regular and called meetings of the Council during the year. The Vice Councilor of the Third District attended both meetings of the Third District Medical Society, and worked with the Councilor and other District Officers in informing the membership of the Medical Association of Georgia activities.

REFERENCE COMMITTEE RECOMMENDATION—The report of the Third District Councilor and the Late Report of the Third District Vice Councilor were accepted and approved.

HOUSE OF DELEGATES ACTION—Adopted the report of the Third District Councilor and Late Report No. 1 of the Third District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fourth District Councilor

VIRGIL B. WILLIAMS, M.D., *Griffin*

The Councilor of the Fourth District has attended all regular meetings of the Council during the past year.

Formal and informal consultations have been held with members of the Association residing in the Fourth District. During the year the Councilor has remained in contact with activities of all societies in his district. Problems concerning organization and ethics assigned by Council have been completed.

The Councilor was instrumental in planning a meeting of representatives of the old Fourth and new Sixth District Societies for the reorganization of the new Sixth District Society.

The Councilor has been ready at all times to advise on problems pertaining to the office.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Clayton-Fayette				
Wells Riley				
Jonesboro	5	5	5	5
Coweta				
W. E. Barron				
Newnan	19	15	21	14
Lamar				
S. B. Traylor				
Barnesville	4	4	4	4



Meriwether-Harris				
Emmett Collins				
Manchester	14	11	16	8
Newton-Rockdale				
E. J. Callaway				
Covington	12	9	11	8
Spalding				
Arthur Krepps				
Griffin	43	38	44	37
Troup				
J. F. Krafka				
LaGrange	42	34	42	33
Upton				
L. L. Allen				
Thomaston	17	14	16	13
	156	130	159	122

REFERENCE COMMITTEE RECOMMENDATION—The report of the Fourth District Councilor was accepted and approved.

HOUSE OF DELEGATES ACTION—Adopted the report of the Fourth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

## AMA Delegates

J. W. CHAMBERS, M.D., *LaGrange, Chairman*  
J. FRANK WALKER, M.D., *Atlanta*  
HENRY H. TIFT, M.D., *Macon*  
PRESTON D. ELLINGTON, M.D., *Augusta*

Your American Medical Association delegation has tried to fulfill its obligations to you completely for this year. Since January 1, 1965 until December 31, 1965 there were two called meetings and two regular meetings of the American Medical Association House of Delegates for the first time in the American Medical Association history.

Since our last Annual meeting your American Medical Association delegation has consisted of four Delegates and four Alternates. At each meeting since that time your representation has been virtually 100 percent, I am happy to say. In addition, each meeting has been attended by the Secretary of your Association and the President or the President Elect, or all three.

As most of you know, both the so-called Medicare Law and the law relating to heart disease, cancer and stroke were passed since our last MAG Annual meeting. Because of the mass of material which has been discussed relating to these, it would be impossible to include a written report for this Handbook. Therefore, I am sure I speak for your entire delegation in saying that we will appear before the properly designated Reference Committee in order to try to give the maximum information to this House.

May I assure you from all of us it is a pleasure to serve you.

REFERENCE COMMITTEE RECOMMENDATION—The MAG Delegates to the AMA are: J. W. Chambers, M.D., LaGrange, Chairman; J. Frank Walker, M.D., Atlanta; Henry H. Tift, M.D., Macon; and Preston D. Ellington, M.D., Augusta. Each AMA Delegate was in attendance at this Reference Committee meeting.

Dr. Chambers reported that the four resolutions submitted from the House of Delegates of the MAG were presented to the House of Delegates of the AMA at its June, 1965 Annual meeting.

Dr. Chambers reported in summary that the October 1965 called meeting of the House of Delegates of the AMA

in Chicago, Illinois, dealt primarily with discussions relative to the relationship of doctors of medicine, Medicare, and the Sherman Anti-Trust Act.

Dr. Chambers reported that at the Clinical Session of the AMA meeting in November, 1965, held in Philadelphia, Pennsylvania, that the Board of Trustees of the AMA proposed to present to the House of Delegates of the AMA at its June, 1966 meeting, to become effective the first of January, 1967, an increase in AMA annual dues of \$25.

Our AMA Delegation feels that the \$25 increase in annual dues is necessary and justified and unanimously supported and spoke for the projected increase.

Reference Committee No. 2, after hearing the presentation of our AMA Delegates recommends to this 1966 House of Delegates of the Medical Association of Georgia that our AMA Delegation be instructed to vote in favor of the AMA increase in annual dues.

Reference Committee No. 2 wishes to express to Henry H. Tift, M.D., Macon, our appreciation of his leadership and dedication to organized medicine and his faithful and excellent service as AMA Delegate from MAG.

This report of the AMA Delegates was accepted with approval and commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the AMA Delegates with the additional recommendation made by the Reference Committee in instructing the MAG Delegates to the AMA to vote in favor of the AMA increase in annual dues on motion duly made and seconded.

## Alternate Delegate

T. A. SAPPINGTON, M.D., *Thomaston*

I have attended each meeting of the AMA House of Delegates during the past year as an Alternate Delegate. I have tried to assist the Delegates to the best of my ability by attending Reference Committees and reporting back to the MAG delegates as to the deliberations of the Reference Committee while it was in open session.

I have attended each meeting of the Council of MAG and have tried to enter into the discussions only when I felt that I might possibly add something to the discussions at that time.

## Alternate Delegate

JOHN KIRK TRAIN, M.D., *Savannah*

This is my first year as Alternate Delegate to the American Medical Association for the Medical Association of Georgia. I have attended both AMA meetings, the New York City Annual Session and the Philadelphia Clinical Session. I came away from both meetings greatly impressed by the amount of work done by the Delegates at the meetings, and the time and thought put into the deliberations of the House of Delegates. The questions facing organized medicine today are multiple and they were all attacked with vim and vigor by the elected representatives of organized medicine on the floor of the House of Delegates.

## Alternate Delegate

JOHN S. ATWATER, M.D., *Atlanta*

It has been a real privilege to have had the opportunity of representing the members of the Medical Association of Georgia as Alternate Delegate to the American Medical Association in 1965.

It was my privilege to attend and actively participate in the annual session of the House of Delegates of the American Medical Association in New York City. All



meetings of the House were attended and your Delegate participated actively in the discussions of the various reference committees to which he was assigned.

It is my feeling that there must be maintained strong liaison between the state medical society and the American Medical Association since the problems of one are invariably the problems of the other. This becomes even more true with the new federal legislation. It is hoped that the close harmony that has existed between the Delegates and Alternate Delegates of the Medical Association of Georgia and their contribution to the internal affairs of the House of Delegates of the American Medical Association may be continued.

Once again, may I state that it has been a real privilege and honor to represent the members of the Medical Association of Georgia as an Alternate Delegate.

**REFERENCE COMMITTEE RECOMMENDATION**—The reports of the AMA Alternate Delegates from MAG, T. A. Sappington, M.D., Thomaston; John Kirk Train, M.D.,

Savannah, and John S. Atwater, M.D., Atlanta, were received and approved with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the reports of the AMA Alternate Delegates as recommended by the Reference Committee on motion duly made and seconded.

**Finance**

F. G. ELDRIDGE, M.D., *Chairman*

The Finance Committee of the Medical Association of Georgia is composed of F. G. Eldridge, Valdosta, Chairman; Charles E. Bohler, Brooklet; and W. Frank McKemie, Albany.

Response to a request of each Committee for budget needs met with excellent response and the budget was formulated well within the anticipated income for the year 1965-66. The proposed budget was accepted by the Executive Committee and full Council and is listed elsewhere in the report of the MAG.

	1965 Budget	Actual Jan. 1-Nov. 30, '65	1966 Proposed Budget
<b>INCOME</b>			
I. (a) MAG Dues .....	\$118,000.00	\$117,047.50	\$119,000.00
(b) Int. & AMA .....	5,225.00	5,245.50	5,500.00
(c) GP Service .....	3,250.00	2,780.00	3,250.00
II. ANNUAL SESSION .....	7,350.00	8,225.00	7,875.00
III. JOURNAL .....	32,500.00	25,374.45	37,550.00
IV. CONTINGENT			
1964 Excess .....	1,155.73		
Trans. fr. Opr. Capital .....	5,000.00	6,155.73	
TOTAL INCOME .....	\$172,480.73	\$164,828.48	\$173,175.00
<b>EXPENSES</b>			
I. (a) Fixed Allot. ....	\$ 14,425.00	\$ 9,658.30	\$ 17,400.00
(b) Assoc. Office .....	86,635.83	71,251.40	95,753.14
(c) Assoc. Boards .....	18,870.00	12,034.77	17,556.00
(d) Rel. MAG Act. ....	1,400.00	1,054.22	1,600.00
(e) Cont. Fd., '64 .....	1,155.73		
Cont. Fd., '65 .....	2,584.82		
Tr. fr. Opr. Cap. ....	5,000.00	5,880.16	3,324.38
II. JOURNAL .....	42,409.35	38,468.21	37,541.48
	\$172,480.73	\$138,347.06	\$173,175.00
<b>I. (a) FIXED ALLOTMENTS</b>			
Payment of Mortgage .....	\$ 4,000.00		\$ 4,000.00
Interest on Mortgage .....	750.00		550.00
MAG Atty. Ret. ....	3,600.00	\$ 2,700.00	3,600.00
MAG Atty. Expenses .....	300.00	248.29	300.00
Woman's Auxiliary .....	1,875.00		
Pension Payments .....	2,400.00	1,650.00	2,400.00
Pres. Honorarium .....	1,000.00	1,000.00	2,400.00
Annual Audit .....	500.00	500.00	500.00
Taxes .....		3,560.01	3,500.00
Ret. Fd. Trust. Serv. ....			150.00
(A) Sub-Total .....	\$ 14,425.00	\$ 9,658.30	\$ 17,400.00
<b>(b) ASSOCIATION OFFICE</b>			
Salaries .....	\$ 55,325.00	\$ 46,926.82	\$ 60,020.00
Ins. & Bonds .....	1,300.00	1,208.60	2,850.00
Payroll Tax .....	2,185.83	1,270.27	2,418.14



Travel-Pres. ....	1,500.00	1,319.16	1,500.00
Travel-Office ....	2,500.00	2,486.48	2,500.00
Travel-Del., Sec., AMA			
Ann. & Clin. Sess. ....	3,000.00	3,000.00	3,800.00
Alt. Del. Transp. ....	1,300.00	583.15	3,040.00
Maint. & Rep.:			
Building ....	750.00	547.52	750.00
Equipment ....	500.00	491.30	500.00
Tel. & Tel. ....	4,000.00	3,589.78	4,000.00
Depreciation:			
Building ....	2,000.00		2,000.00
Equipment ....	650.00		650.00
Postage ....	3,000.00	2,862.44	3,000.00
Office Supplies ....	2,750.00	2,228.63	2,750.00
Janitor Serv. & Grat. ....	2,000.00	1,398.22	2,000.00
Meetings ....	800.00	634.34	800.00
Dues & Sub. ....	375.00	345.00	375.00
Heat, Light & Water ....	2,400.00	2,214.29	2,500.00
Sundry ....	300.00	145.40	300.00
	<u>\$ 86,635.83</u>	<u>\$ 71,251.40</u>	<u>\$ 95,753.14</u>

#### (c) ASSOCIATION BOARDS

1. Annual Session ....	\$ 7,210.00	\$ 6,189.70	\$ 8,611.00
2. Const. & By-Laws			
3. Hospital Relations ....	50.00		50.00
a. Blood Banks ....	150.00	60.28	
b. Hosp. Relations ....	50.00		
4. Govern. Med. Serv. ....	100.00		50.00
a. Crippled Child.			
b. Dist. Med. Care ....	200.00	128.31	200.00
c. Mat. & Inf. Wel. ....	300.00	104.57	350.00
d. Public Health			
e. Rehabilitation			
f. Sch.-Child. Hel. ....	1,500.00	847.51	1,000.00
g. Vet. Affairs ....			
5. Ins. & Economics ....	500.00	8.24	700.00
a. Re. Value Std. ....	2,500.00	484.47	
6. Interprof. Rel. ....	125.00	125.00	125.00
a. Nurs. Liaison			50.00
7. Legislation ....	2,000.00	2,000.00	2,500.00
8. Medical Education ....	650.00	503.90	
a. AMA-ERF ....	35.00		45.00
b. Clks. Labs.			
9. Occup. Health ....	300.00		300.00
b. Rural Health ....	400.00	392.70	900.00
10. Public Service ....	1,900.00	1,164.32	1,925.00
c. Med. & Rel. ....	200.00		
11. Spec. Activities			50.00
a. Health Care of Ag. ....	400.00		
12. Vol. Health Agencies ....	50.00		350.00
a. Cancer ....	50.00	25.77	100.00
b. Mental Health ....	200.00		250.00
(C) Assoc. Boards Total ....	<u>\$ 18,870.00</u>	<u>\$ 12,034.77</u>	<u>\$ 17,556.00</u>

#### (d) RELATED MAG ACTIVITIES

AMA Del. Meeting ....	\$ 500.00	\$ 458.56	\$ 800.00
Medical Defense ....	300.00	25.00	200.00
SAMA ....	500.00	500.00	500.00
SMEB ....	100.00	70.66	100.00
(D) Sub-Total ....	<u>\$ 1,400.00</u>	<u>\$ 1,054.22</u>	<u>\$ 1,600.00</u>



(e) **CONTINGENT (1964)**

Contingent (1965) .....	\$ 1,155.73		
Tr. fr. Opr. Cap. ....	2,584.82		
*Retirement Fund .....	5,000.00	\$ 125.00	
Retirement Cont. ....		2,400.00	
*Accident Insurance .....		353.50	
*Workmen's Comp. ....		186.50	
*Catastrophic Ins. ....		271.49	
GaMPAC .....		1,000.00	
*Legislation .....		649.91	
*President's Honorarium .....		700.00	
AMA Delegates .....		193.76	
* Items budgeted 1966	\$ 8,740.55	\$ 5,880.16	

**II. JOURNAL**

Expenses:			
Printing .....	\$ 30,000.00	\$ 27,623.99	\$ 26,000.00
Salaries .....	8,267.50	7,443.75	8,267.50
Insurance .....	200.00	196.51	227.20
Payroll Taxes .....	441.85	283.36	596.78
Engr. & Cuts .....	1,400.00	1,216.51	1,400.00
Sales Tax .....	900.00	547.23	
Postage .....	300.00	398.48	650.00
Stationery .....	600.00	315.18	100.00
Clipping Service .....	150.00	127.70	150.00
Add. & Sup. ....	100.00	138.41	100.00
Sundry .....	50.00	177.09	50.00
	\$ 42,409.35	\$ 38,468.21	\$ 37,541.48

**REFERENCE COMMITTEE RECOMMENDATION**—Report of the Finance Committee of MAG, F. G. Eldridge, M.D., Valdosta, Chairman; Charles E. Bohler, M.D., Brooklet; and W. Frank McKemie, M.D., Albany, was received and approved with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Finance Committee as recommended by the Reference Committee on motion duly made and seconded.

**Woman's Auxiliary to the Medical Association of Georgia**

MRS. LOUIE H. GRIFFIN, SR., *President*

For many years it has been rumored that among some members of the men's organization there was a notable lack of recognition and understanding of the Auxiliary's worth. Perhaps one has to attain this high office to finally know that the rumors are actually unfounded. This year has proven for me that not only have we had the upmost cooperation but we have been highly rewarded by encouragement in our efforts, by being invited to the county societies' planning sessions and by acknowledgements from many members and one society, especially, of our endeavors in the various health related projects that we carry on.

This year the Auxiliary has attempted to carry on the many projects to which it is obligated through the national organization and to highlight one special committee, that of Health Careers. Some effort has been made in nearly every one of the 41 Auxiliaries to accelerate this project. We have many nursing scholarships being provided by Auxiliaries over the State, Allied Medical Careers Clubs being sponsored by Auxiliaries, Health Career Days being planned, winners of Science Fairs being rewarded by members of the medical profession and Auxiliary. These have been part of our effort to-

ward providing the many people needed to carry on the work of our doctors and but for the encouragement that we give, many of these people would not see the need to enter these allied fields.

This has been a year of progress and plans for the future. We have begun a project on Health Education. This was presented to the Auxiliary by AMA at our Fall Conference in Chicago. It has been a project since 1962 and it was felt by AMA that the Auxiliary could better carry out the many facets of this program. We have begun by presenting this information to the schools. The racks of health material in readable form is popular with young people and provides much needed information from the right source on a variety of subjects. The Medical Association can help the Auxiliary with this project by inquiring if it is being carried on in your area and by giving active financial support, if needed.

Our Advisory Board has been most attentive and helpful this year and we would commend each one. They have given us constructive criticism and have been represented at each of our meetings, always available for advise and encouragement. It is being recommended to our county auxiliaries that they send a copy of their yearly report to their corresponding county medical society. This will make for better understanding and our work evaluated.

The recommendation made last year that the Auxiliary become 100% membership with the men's organization was good, but it thought best to leave this up to the counties. This is still an excellent idea, where feasible—and could be an added impetus to auxiliary planning.

Your approval is the key to our progress—we are "an auxiliary!" In some counties, we have the habit of pay-



ing dues and socializing—this in itself discourages other members. This is a service organization and the work is far-reaching. Our work in Community Service, International Health, Disaster Preparedness, Safety, Rural Health, AMA-ERF, Mental Health, Legislation and our own William R. Dancy, M.D. Student Loan Fund deserves the support and active participation of all doctors' wives. Our Fund has a net worth of \$32,000.00. We have 20 loans outstanding at this time, seven of these having been made this year. We would recommend support and more publicity among the profession for the William R. Dancy, M.D. Student Loan Fund.

Many boxes of sample drugs, medical books, medical magazines and small instruments have been shipped overseas in the past few years. This project also should be encouraged where there is no active auxiliary. These could be packed and shipped by obtaining the correct addresses from the state chairman. Many ideas have occurred to me this year during my visits to the county groups. None has held my imagination like that of "a better relationship one with the other, wives and doctors in their sense of responsibility toward the medical profession, in community service, public relations, legislation and all health related activities."

Because of the esteem in which the medical profession is held, it behooves us all to become better acquainted with each other and the things that we value. These are being slowly drained away and we need to lean one upon the other in these "changing times," less our voices be lost in the hue and cry of the "Great Society."

It has been a pleasure to serve as the President of the Woman's Auxiliary to the Medical Association of Georgia and to have a part in advancing the goals of these organizations.

**REFERENCE COMMITTEE RECOMMENDATION—**The Committee wishes to express our warm and sincere appreciation to Mrs. Louie H. Griffin, Sr., President of the Woman's Auxiliary to the Medical Association of Georgia, and to every member of the Woman's Auxiliary of MAG for their continued faithful support, their excellent leadership projects, and their continued diligent dedication. We accept their report with approval and commendation.

**HOUSE OF DELEGATES ACTION—**Adopted the report of the Woman's Auxiliary to the Medical Association of Georgia as recommended by the Reference Committee on motion duly made and seconded.

## Resolution No. 2

### **MAG ESTABLISHES POLICY CONCERNING RELATIONS BETWEEN GOVERNMENT AND MEDICAL PRACTITIONERS**

J. T. CHRISTMAS, *Flint County Medical Society*

**WHEREAS:** The private practice of medicine is rapidly becoming more subject to Government control and

**WHEREAS:** The rules and regulations promulgated to administer the laws regarding the practice of medicine are subject to change at the whim of salaried bureaucrats and

**WHEREAS:** It appears that many of these rules and regulations flagrantly violate the physician's freedom to practice his art and

**WHEREAS:** This is not in the best interest of the patient nor the physician,

**NOW BE IT RESOLVED:** That the Medical Association of Georgia issue a statement of policy similar to that adopted by the AMA House of Delegates—that attempts by Federal Agencies to impose conditions and

pledges upon the medical profession should be forcefully opposed and

**BE IT FURTHER RESOLVED:** That the right of the individual physician to set policy concerning his private practice of medicine be maintained and

**BE IT FURTHER RESOLVED:** That the Medical Association of Georgia support and work through its officers actively for the establishment of a plan whereby the physician may by his own choice elect to receive reimbursement for his services either from the patient or the government carrier without jeopardizing the patient's benefits under the law regardless of which agency administers the Federal funds and

**BE IT FURTHER RESOLVED:** That the Medical Association of Georgia, through its Executive Committee, work with the other State Associations and the AMA in an effort to preserve the Doctor-Patient relationship, voluntary service to humanity and independence in the practice of medicine.

**REFERENCE COMMITTEE RECOMMENDATION—**This Resolution No. 2 was accepted and approved.

**HOUSE OF DELEGATES ACTION—**Adopted Resolution No. 2: MAG Establish Policy Concerning Relations Between Government and Medical Practitioners as recommended by the Reference Committee on motion duly made and seconded.

## Resolution No. 7

### **HOSPITAL OPERATING POLICIES**

ALEX P. JONES, *Spalding County Medical Society*

**PREAMBLE:** The primary objective of hospitals and the medical profession has been the diagnosis, care and cure of people suffering from disease or injury, but with the growth of power being invested in governmental agencies by the great society concept, the hospitals and the medical profession are being forced to concern themselves with social reforms. These agencies, through threats of withholding funds needed to maintain modern facilities for the treatment and care of the sick or funds to pay for the services already rendered, are seeking to bring about social reform by formulating admission and bed assignment policies. Social reform efforts in hospitals, through bed assignment, does not and will not contribute anything in the treatment or cure of the ill or injured patient, but in some instances, will deter, interfere or prolong the treatment where such efforts of social reforms are forced upon an already ill patient who would resent such intrusion into his personal life. The hospital patient finds himself in a strange, frightening environment where his life and body are bared and he resents being ill. The patient's room and bed assignment should be according to medical indications, age and personality. The use of the helpless, hapless patient to force social reform by government agencies and politicians is criminal and the hospitals and medical profession should protest their intrusion into the privacy of the patient.

**WHEREAS,** the hospitals and medical profession are concerned with the diagnosis and treatment of illness and injury, and

**WHEREAS,** the hospitals and medical profession have never considered race, creed, religion or national origin in their diagnosis or treatment of the ill or injured patient, and

**WHEREAS,** bed and room assignments in the hos-



pitals are based upon medical indications, sex of the patient, age and the personality and preference of the patient, and

WHEREAS, bed and room assignments are not part of the diagnostic procedures or treatment, and

WHEREAS, the patient is under emotional stress due to his illness or injury and finds himself in a strange environment, and

WHEREAS, further emotional trauma would be harmful to the helpless, hapless hospital patient, and

WHEREAS, there are efforts being made by governmental agencies and politicians to bring about social reform by the use of unwilling, defenseless patients for political gain rather than a concern for the patient's welfare, and

WHEREAS, these agencies and politicians seek to force the hospitals and medical profession to participate in their efforts through the use of threats, coercion and retaliation by withholding funds, appropriated by Congress, for the improvement of medical care facilities or in payment of the costs of services already rendered, and

WHEREAS, these agencies and politicians seek to bring about social reform by bed and room assignment policies which totally disregard to medical indications, ages of the patients, sex, personality or the preference of the patient, and

WHEREAS, social reform is a matter of public education and not a part of the treatment of the ill or injured;

BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia go on record as opposing the use of patients to bring about social reform by federal agencies and politicians through intimidation of hospitals and efforts to formulate admission policies without regard to the interest of patient care, and

BE IT FURTHER RESOLVED, that the Delegates to the American Medical Association be instructed to present this resolution to the House of Delegates of the American Medical Association, and

BE IT FURTHER RESOLVED, that the American Medical Association, through its Washington office, inform members of Congress, members of the Senate and HEW, that they oppose the use of hospital patients by agencies in an effort to promote social reform with complete disregard of patient care and the entry of these agencies into the formulation of admission policies, and

BE IT FURTHER RESOLVED, that the AMA and AHA oppose the intimidation and threats of withholding funds as being contrary to the best interest of all patients for it would impede expansion and modernization and the payment of services already rendered, and

BE IT FURTHER RESOLVED, that the AMA and the AHA back any institution which refuses to permit the use of the ill or injured patient as political pawns by agencies of the federal government, and

BE IT FURTHER RESOLVED, that the AMA goes on record as opposing the entry of any governmental agencies into areas which concern the treatment of patients as this should remain in the scope of the medical profession, the hospital and the patient, with the individual freedom of the patient and medical judgment as the only criteria for policies of operation.

This resolution is respectfully submitted by the

Spalding County Medical Society in an effort to place the patient's interest in the correct prospective and remove him from the status of being used as a political pawn by governmental agencies without regard to his medical or personal needs.

REFERENCE COMMITTEE RECOMMENDATION—This Resolution No. 7 was approved with the amendment to the report as drafted by this Reference Committee as follows:

“WHEREAS, the hospitals and medical profession are concerned with the diagnosis and treatment of illness and injury, and

“WHEREAS, bed and room assignments in the hospitals are based upon medical indications, sex of the patient, age and the personality and preference of the patient, and

“WHEREAS, the patient is under emotional stress due to his illness or injury and finds himself in a strange environment, and

“WHEREAS, there are efforts being made by government agencies and politicians to bring about social reform by the use of unwilling, defenseless patients for political gain rather than a concern for the patient's welfare, and

“WHEREAS, these agencies and politicians seek to force the hospitals and medical profession to participate in their efforts through the use of threats, coercion and retaliation by withholding funds, appropriated by Congress, for the improvement of medical care facilities or in payment of the costs of services already rendered, and

“WHEREAS, social reform is a matter of public education and not a part of the treatment of the ill or injured;

“BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia go on record as opposing the use of patients to bring about social reform by federal agencies and politicians through intimidation of hospitals and efforts to formulate admission policies without regard to the interest of patient care, and

“BE IT FURTHER RESOLVED, that the Delegates to the American Medical Association be instructed to present this resolution to the House of Delegates of the American Medical Association, and

“BE IT FURTHER RESOLVED, that the American Medical Association, through its Washington Office, inform members of Congress, members of the Senate and HEW, that they oppose the use of hospital patients by agencies in an effort to promote social reform with complete disregard of patient care and the entry of these agencies into the formulation of admission policies.”

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 7: “Hospital Operating Policies” as amended by the Reference Committee on motion duly made and seconded.

## Resolution No. 9

### EYE RESEARCH

L. HARVEY HAMFF, *Fulton County Medical Society*

WHEREAS, Blindness has increased over 340% in the United States in the past 5 years, and

WHEREAS, Funds are greatly needed for Teaching and Research in Diseases of the Eye.

THEREFORE BE IT RESOLVED, that the MAG endorses and supports as a fund raising project of the Atlanta Lions Club—the presentation of a Grand Prix Sports Car Race at Stone Mountain Park—as an annual event—to raise funds for promotion of eye research in the State of Georgia.

FURTHERMORE, The MAG urgently appeals to the Stone Mountain Association to grant permission for this event which will benefit the State of Georgia economically, and will benefit all of mankind as well.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee received and approved Resolution No. 9 with the deletion of the two words “and supports” in paragraph number three, first line.



**HOUSE OF DELEGATES ACTION**—Adopted the Resolution No. 9: "Eye Research" as amended by the Reference Committee on motion duly made and seconded. The amended Resolution adopted reads as follows:

"WHEREAS, Blindness has increased over 340% in the United States in the past five years, and

"WHEREAS, Funds are greatly needed for teaching and research in diseases of the eye,

"THEREFORE BE IT RESOLVED, that the MAG endorses as a fund raising project of the Atlanta Lions Club—the presentation of a Grand Prix Sports Car Race at Stone Mountain Park—as an annual event—to raise funds for promotion of eye research in the State of Georgia,

"FURTHERMORE, the MAG urgently appeals to the Stone Mountain Association to grant permission for this event which will benefit the State of Georgia economically and will benefit all of mankind as well.

It was moved by Reference Committee No. 2 Chairman Henry Scoggins, Augusta, and duly seconded that the report of the Reference Committee be approved as a whole and it was so ordered.

At this time, Speaker Walker turned the gavel over to Vice-Speaker Harrison Rogers, Atlanta.

### Report of Reference Committee No. 3

W. P. Rhyne, Albany, Chairman

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)*

Reference Committee No. 3 met in the Gold Room of the Ralston Motor Hotel, Columbus, Georgia, at 2:30 p.m., on May 9, 1966. Members present were: W. P. Rhyne, Albany, Chairman; J. Watts Lipscomb, Forest Park, Secretary; Robert Moye, Swainsboro; A. Richard Gray, Rome; Milton Johnson, Macon; Irving Greenberg, Atlanta; and Don Schmidt, Cedartown.

In the absence of Chairman W. P. Rhyne, the following report was presented by J. Watts Lipscomb, Forest Park, Reference Committee No. 3 Secretary.

#### President

GEORGE H. ALEXANDER, M.D., Forsyth

I am going to begin this report with a quote from J. G. McDaniel—my predecessor: "It's downright sinful the pleasure I get in deferring things for the next President to decide." It hasn't been that bad really. Quite true—I couldn't honestly say that it has been an easy year.

This year just coming to a close has, as I am sure many of you realize, been a year which has presented many problems. Also, I am well aware that in all probability Walter Brown and his successors for the next few years will be confronted with more problems than we have this year.

For the moment, let's forget about Medicare and some of the problems related to it, and go back to a year ago and some of the things which we hopefully wished to accomplish.

You will recall that last May I spoke of the possibility of holding another conference on Medical Education, similar to the one held at Callaway Gardens in

January last year. As we got into the year, however, it was decided that it was a bit early to hold a conference with a format similar to the one held last year. In the interest of space, I would like to refer you to the President's Letter for March in which the relationship of the Heart Disease, Cancer and Stroke Legislation to Continuing Medical Education was discussed. As brought out at that time, there are wonderful possibilities for Continuing Medical Education in this Program. I believe that in cooperation with the medical schools, we will get "this ball rolling" and that it will mean much.

Another facet of education discussed by me was the need for the training of more paramedical personnel. The Heart Disease, Cancer and Stroke Program will probably contribute greatly to this need, but in the meantime, the Medical Association of Georgia Ad Hoc Committee on paramedical education is making progress.

You will recall that not only did I, but also our Secretary, John Mauldin, discuss the problem of medical ethics. During the year, we have had an Ad Hoc Committee working on this problem and they will present proposed amendments through the Board of Constitution and Bylaws to amend the Bylaws more clearly, defining the duties of the Professional Conduct Committee.

The American Medical Association Judicial Council had planned a National Conference on Medical Ethics for last October, and following this we had expected to have a similar State level conference at the time of our County Medical Society Leadership Conference. The American Medical Association Conference was preempted by the special called meeting of the House of Delegates on Medicare. Accordingly, our State conference did not occupy as large a role as planned. Those of you who attended the Leadership Conference must have been tremendously impressed, as was I, by that segment of the program presented by the panel on medical ethics. The American Medical Association Conference was held in Chicago March 5-6, and it is my recommendation that a State conference be held during the coming year. What has just been said is not intended in any manner to subordinate the other portions of the program of the Leadership Conference. It was one of the best attended and presented one of the best overall programs we have had.

One of the more important things to happen this year was the joint meeting of the Medical Association of Georgia Council and the physician members of the State Board of Health. This meeting was triggered by Medicare and the problems presented by the designation by the Governor of a State Administrative Agency. It did much to "clear the air" and, in my opinion, has done much to promote a better understanding between the Board of Health and the MAG Council of the problems of one another. Since this meeting, the President or a member of Executive Committee has attended all Board meetings, and the Board Chairman or a representative has attended Council meetings.

During February a survey was made of our Headquarters Office procedures and management. This survey and its follow-up report was done by Mr. Donald Taylor, Executive Vice President of the Iowa Medical Society. He had a number of suggestions and Milton Krueger says "he was shook." I know though that there also were many good things noted—also areas for improvement were pointed out.

To enumerate and discuss many other things would



prolong this report unduly—particularly since so many activities will be covered by the reports of other officers, the Council and Committees and Boards. Therefore, I will do some summing up and make some recommendations.

Before this summation though, it might be well to enumerate some of the problems and activities of the year—even though many of them will be covered in other reports. I think the following deserve mentioning:

(1) There have been three meetings of the AMA House of Delegates—The Annual Session in New York in June; the special called meeting on Medicare in Chicago in October and the Clinical Session in Philadelphia in November.

(2) I have made a number of out-of-state trips since March 1965, including the three meetings of the House of Delegates. All told, I have been to Chicago four times, New York once, Philadelphia once and Washington three times. The last Washington trip was in November for the White House National Conference on Health (see President's Letter for January). The expense for part of this travel was reimbursed by AMA.

(3) The MAG has co-sponsored with the Board of Regents the two year associate degree in nursing program.

(4) The change in the printing contract for the Journal, which will be covered in a separate report.

(5) The change in the format of the Annual Session, which it is hoped you will like and which hopefully will result in more members attending the Annual Session and staying on throughout its conclusion.

(6) The revision in the MAG insurance program on which you already have received information and on which there is a separate report.

(7) The formation of the Fee Schedule Negotiating Committee and its fine work in several areas.

(8) The fine Rural Health Conference at Rock Eagle Park.

(9) The work done during the session of the General Assembly and on which there will be a separate report.

(10) The Talmadge Hospital Liaison Committee has met and is showing evidence of functioning well.

(11) A State (MAG) level Hospital Utilization Committee has been set up to work and advise with local committees.

(12) There have been several negotiating conferences on Medicare. The John Hancock Mutual Life Insurance Company has been named as intermediary for Part B of Title 18 for Georgia. Conferences have been held with them in order to try to follow Council's directive to have "an integral part" in the program regardless of who might be named as intermediary.

(13) The Board of Constitution and Bylaws has been working to review our Constitution and Bylaws and will recommend several things in its report.

A difficult year in many respects—yes. Many rewarding experiences—very definitely—yes. There was a time last August when I was advised that it might be well for me to resign. I elected not to do so and fortunately was able to obtain another young physician to help me. He, along with the other faithful and loyal employees in my office, have been a tremendous help. Without them and the assistance of the MAG Officers, Council and Headquarters' Staff, I am sure I couldn't have continued. No one has failed to respond when help was asked for.

I certainly would be remiss if I did not also remember the help my good wife has been. She has chauffeured me many miles and been a wonderful companion and help in many other ways.

In addition to those already made, I have a few more recommendations:

(1) Although the Board of Constitution and Bylaws may not agree, I would like to recommend that consideration be given to the idea of making the Speaker of the House of Delegates an Ex-officio member of the Executive Committee.

(2) I realize that the Executive Committee is large enough, but because the Second Vice President automatically succeeds to the First Vice Presidency, he definitely would be more knowledgeable and useful when that time comes if he also were made an Ex-officio member of Executive Committee and I so recommend. (The Constitution and Bylaws report may recommend this too.)

(3) During my tenure, there have been an increasing number of occasions for out-of-state travel for the President Elect. Executive Committee has allowed him on occasion to share in the President's travel allowance. This is good, because by so doing he is better equipped to become President. I think it would be wise for the House of Delegates to act upon this officially by making a limited number of trips by the President Elect possible.

Again, I want to say that in spite of the rough spots, it has been a wonderful year. I wouldn't take anything for it.

My best wishes to Walter Brown for a fine year. He is going to need your support and encouragement. Give it to him!!!

**REFERENCE COMMITTEE RECOMMENDATION**—The President's report was approved with commendation with the exception of disapproval of Recommendation No. 3, which is concerned with travel expenses for the President-Elect, because such expenses can presently be provided with approval of the Council, and without action of the House of Delegates.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the President as amended by the Reference Committee on motion duly made and seconded.

Seventh District Councilor

RALPH N. JOHNSON, M.D., *Rome*

The Seventh District is steadily growing. We have 18 more members than we had a year ago and Cobb County has grown enough to warrant their own Councilor.

We are anxiously waiting to see how Medicare will affect the practice of medicine in our area but will have to wait until July 1 to see.

Your Councilor has attended all of the meetings during the past year and is looking forward to the annual State meeting in May.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Bartow				
Virginia Hamilton				
Cartersville . . . . .	9	7	8	6
Carroll-Douglas-Haralson				
Frank Green				
Villa Rica . . . . .	34	29	33	29



Chattooga				
Herman E. Spivey				
Summerville	6	6	7	7
Cobb				
W. B. Matthews				
Marietta	112	105	102	95
Floyd				
Richard W. Leigh				
Rome	71	65	69	61
Gordon				
L. R. Lang				
Calhoun	10	8	9	7
Polk				
Ben Anderson				
Cedartown	13	11	12	10
Walker-Catoosa-Dade				
Gordon L. Hixson				
Ft. Oglethorpe	32	22	33	23
Whitfield				
M. B. Lumpkin				
Dalton	40	34	36	31
	327	287	309	269

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepted this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Seventh District Councilor as recommended by the Reference Committee on motion duly made and seconded.

### Eighth District Councilor

F. G. ELDRIDGE, M.D., *Valdosta*

All meetings of Council were attended by your Councilor except one during the past year. As a member of the Executive Committee of Council all meetings were attended.

At the request of the members of the Cook-Berrian County Society, the Charter for this group has been abandoned and the members have indicated they will seek a return to the South Georgia Society.

Council has been coming to Valdosta for the December meeting for several years and we have been fortunate to entertain the members and their wives at this time.

During the fall meeting in October, the Eighth District decided to return to resumption of two meetings a year, with the spring meeting to be held the second Tuesday in April.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG Dues Paying Only	AMA	MAG Dues Paying Only	AMA
Altamaha				
Horace L. Morgan				
Baxley	9	8	10	9
Coffee				
John W. Herndon				
Douglas	11	9	9	5
Cook-Berrien				
Y. F. Carter				
Nashville	8	7		
Camden-Charlton				
H. H. Robinson				
Kingsland	10	8	8	8
Glynn				
Pearl B. Waddell				
St. Simons Island	49	45	49	45
South Georgia				
Byron S. Davis				
Valdosta	53	46	57	50

Telfair				
D. B. McRae				
McRae	6	6	6	6
Ware				
J. Duncan Farris				
Waycross	46	43	44	36
Wayne				
Daniel H. G. Glover				
Jesup	10	9	10	9
	202	181	193	168

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepted this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Eighth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

### Ninth District Councilor

CHARLES R. ANDREWS, JR., M.D., *Canton*

There are essentially no changes in the status of the Ninth District, as will be seen in the membership breakdown below. The District continues to be very strong in the interest of its members as evidenced by the excellent attendance at the meetings twice a year. The whole society has always presented excellent scientific programs. The meetings for this year were in September at Buford with the Chattahoochee Valley Society as host, and as usual in April with Hall County Society as host. We are also fortunate to have excellent interest and participation by the Auxiliary members throughout the District.

It is the wish of the present officers to attempt to strengthen some of the smaller Societies in the District this year, and it is anticipated that the Ninth District will continue to be one of the outstanding Districts in the State.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG Dues Paying Only	AMA	MAG Dues Paying Only	AMA
Blue Ridge				
James M. Haymore				
Blue Ridge	8	5	9	5
Chattahoochee				
James H. Hunt				
Duluth	18	15	19	17
Cherokee-Pickens				
G. H. Perrow				
Jasper	15	14	15	13
Habersham				
F. O. Garrison				
Cornelia	16	12	16	13
Hall				
Leland L. Pool				
Gainesville	55	49	52	45
Jackson-Barrow				
A. A. Rogers, Jr.				
Commerce	15	13	16	13
Rabun				
Richard J. Turner				
Clayton	4	3	4	3
Stephens				
Charles M. Henry				
Toccoa	17	16	17	16
	148	127	148	125



REFERENCE COMMITTEE RECOMMENDATION—The Committee accepted this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ninth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Ninth District Vice Councilor

PAUL T. SCOGGINS, M.D., *Commerce*

I have attended all meetings except one. Ninth District has been represented at all Council meetings either by Councilor, Vice Councilor or both.

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepted this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ninth District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Tenth District Councilor

ADDISON W. SIMPSON, M.D., *Washington*

The Tenth District Councilor wishes to report a very satisfactory year. The two District meetings were well attended. The scientific programs were of unusually high caliber. The reorganizational meeting was well attended by members from all but one of the component societies.

The members have been kept informed about the political problems as they arose and the need for active participation by the individual physician has been well met at the local level.

I would like to thank Dr. Marion Hubert, Vice Councilor, for his valuable assistance in handling the Councilor's affairs during the time I was unable to carry out these duties.

With the addition of the new counties from the old Sixth District I feel that the new Tenth District will be much more active than in the past. The Tenth acquired several outstanding, organizationally oriented, men whose active participation has already been felt by their presence at the recent meeting. Our old friends from Elbert-Franklin-Hart will be greatly missed. Our loss is the Ninth District's gain. We hope that these good friends will come and meet with us often.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Crawford W. Long				
Harvey Cabaniss				
Athens .....	62	52	57	46
Elbert-Franklin-Hart				
Stewart Brown, Jr.				
Royston .....	22	16	24	17
McDuffie				
John W. Lemley				
Thomson .....	7	6	7	6
Oconee Valley				
H. A. Thornton				
Greensboro .....	12	9	11	8
Walton				
C. C. Moreland				
Monroe .....	10	9	11	9
Warren				
H. B. Cason				
Warrenton .....	1	—	1	—

Wilkes				
C. E. Pollock				
Washington .....	8	6	8	6
	122	98	119	92

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepted this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Tenth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Constitution and Bylaws

W. G. ELLIOTT, M.D., *Chairman*

A meeting of the Board of Constitution and Bylaws of the Medical Association of Georgia was called for November 18, 1965, at 2:00 p.m., at the Medical Association of Georgia Headquarters Office Building, Atlanta, Georgia, to review the Constitution and Bylaws in its entirety as is required every five years. The following were present: Dr. W. G. Elliott, Chairman; Dr. George Alexander, President, Medical Association of Georgia; Dr. Linton Bishop, Atlanta, member of the Board; Dr. John T. Mauldin, Secretary, Medical Association of Georgia; Mr. John L. Moore, legal counsel to the Medical Association of Georgia, and Mr. James M. Moffett, Medical Association of Georgia Staff.

Following thorough discussion and review the Board recommends that appropriate language be adopted to amend the Constitution and Bylaws in the following respects:

1. Election of officers and AMA delegates by the MAG House of Delegates rather than by the general membership.
2. CHAPTER IV, SEC. 3: That the Second Vice President be made an Ex-Officio, non-voting member of the Executive Committee of Council.
3. CHAPTER IV, SEC. 4: Provide that Council shall meet at intervals of not more than three months (they presently meet once each three months, but the Bylaws prescribe that they must meet only as often as once each month).
4. CHAPTER V, SEC. 2: Make a technical change to permit those county medical societies having more than 100 members to elect one or more Councilors and Vice Councilors. The technical change consists of adding the words "or more."
5. CHAPTER VI, RIGHTS AND DUTIES OF OFFICERS: If recommendation number 2 is adopted it will be necessary to make a technical change in this Chapter to so state that the Second Vice President is an Ex-Officio member of Executive Committee.
6. CHAPTER IX: Provide for necessary changes in this chapter for the creation of the following standing committees of the Association:

Executive Committee of Council  
Finance Committee  
Woman's Auxiliary Advisory Committee  
Professional Conduct Committee  
Constitution and Bylaws Committee  
Annual Session Committee

Further provide that all committees shall be appointed on an annual basis (except when terms of office are



set automatically by another section of the Constitution and Bylaws such as Executive Committee and Professional Conduct). Provide further that all other committees will be created and appointed by the Executive Committee, the Council or by the House of Delegates as the needs of the Association require.

7. CHAPTER IV, COUNCIL, SEC. 1: Provide that there shall be no District Medical Society in instances where there is only one component county medical society in the District.

8. CHAPTER IV, SEC. 3: So much of this Chapter and Section as reads "The Executive Committee between meetings of the Council shall have the authority and power of Council in the field of legislative activity" should be amended as follows: The Executive Committee between meetings of Council shall have the authority and power of Council except for expenditure of unbudgeted funds in excess of \$1,000.00

9. CHAPTER V, SEC. 2: Changes made so that this Chapter and Section read that Councilors and Vice Councilors are *elected* (not nominated) by the District Medical Society and by certain larger county medical societies.

The recommended changes here would still permit nominations from the floor and elections held in the event the district and larger county medical societies have not properly elected their Councilors and certified the results of said election to the Headquarters Office at least fifteen (15) days in advance of the Annual Session.

10. CHAPTER V, SEC. 4: If recommendation number one is adopted then this Section should be repealed.

11. CHAPTER II, SEC. 6: This Section provides that the election of the Local Arrangements Committee by the host county medical society for the following year's Annual Session shall take place as soon as practicable following each Annual Session. The Board recommends that this be amended so as to provide for the election of Local Arrangements Committees two years in advance.

12. CHAPTER X, SEC. 3: Recommends that this Chapter and Section be amended so as to repeal that provision whereby \$100.00 legal defense money is paid by the Association for members confronted with malpractice action.

13. CHAPTER IV, SEC. 1: This Section in part reads as follows: "In any district where there is a component county medical society having 100 or more members and there are not at least 50 other members in good standing in the remainder of the district, then just one Councilor and Vice Councilor shall be nominated to represent the district at large and no nominations shall be made by such component county medical society with 100 or more members." This cannot be complied with in the case of the Fifth District and the Fulton County Medical Society inasmuch as they are now one and the same entity. The Board understood the equitable intent of this Section and recommends that its intent be preserved. Accordingly, they instructed MAG Attorney, Mr. Moore, to draft appropriate language to accomplish this purpose.

14. CHAPTER IX, SEC. 2: Following general discussion of the composition and operation of the Committee

on Professional Conduct the Board felt that a thorough review would be in order. Accordingly, it agreed to request the Ad Hoc Committee on Medical Ethics to give its attention and study to the whole area of operation now occupied by the Professional Conduct Committee.

A copy of these recommendations was sent each member of the Board that was not present at the meeting, and they have all agreed with these recommendations.

(NOTE: The remainder of this report consists of: (1) extracts from the existing Constitution and Bylaws by Chapter and Section affected by the proposed Changes; (2) technical language as proposed by the Constitution and Bylaws Board; and (3) recommendations for or against, including amendments, as made by the MAG Council on each proposed change to the Constitution and Bylaws. Extracts from the existing Constitution and Bylaws is printed in regular type; proposed changes recommended by the Constitution and Bylaws Board are printed in **bold face** type; and, the recommendations of the MAG Council are printed in *italics*.)

REFERENCE COMMITTEE NOTE—The Reference Committee elected to consider the report of the Constitution and Bylaws Board section-by-section beginning in the right hand column of Page 23 of the House of Delegates Handbook as follows:

## CHAPTER I. Membership

SECTION 2. The name of a physician recorded on the official roster of a component county society, who has paid the annual dues and assessments of the component county society and of the Association, shall be prima facie evidence of membership in the Association.

### Chapter I, Section 2:

Add to the end of such Section the following sentence:  
"A member suspended or expelled from membership in the Association shall not be a member of Association and shall have none of its privileges during the period of suspension or expulsion even though such member remains a member in good standing of a component county medical society."

*COUNCIL ACTION—Recommend adoption.*

REFERENCE COMMITTEE RECOMMENDATION—Chapter I, Section 2—Membership: The Committee recommended adoption of these changes. The Committee concurred with the intent of the change to allow the Medical Association of Georgia control over the constitution of its own membership and the discipline of its own members.

HOUSE OF DELEGATES ACTION—Adopted the changes in Chapter I, Section 2 recommended by the Constitution and Bylaws Board as recommended by the Reference Committee on motion duly made and seconded.

## CHAPTER II. General Meetings

SECTION 6. LOCAL ARRANGEMENTS COMMITTEE. As soon as practicable following the close of each Annual Session the component society which will act as host at the next Annual Session shall elect Local Arrangements Committees which shall recommend suitable meeting places and shall have general charge of all local arrangements subject to the approval of Council.

### Chapter II, Section 6:

Delete present Section 6 and insert in lieu thereof the following:

"SECTION 6. Invitations from component county medical societies to the Association for its Annual Session shall



be forwarded to Council two (2) years and thirty (30) days prior to the relevant Annual Session. Council shall make recommendations to the House of Delegates two (2) years before each Annual Session as to the site of such Annual Session and the House of Delegates shall decide two (2) years in advance as to the site of the meeting of the particular Annual Session."

*COUNCIL ACTION—Recommend adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter II, Section 6—Local Arrangements Committee: The Reference Committee recommended adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted the change in Chapter II, Section 6 as proposed by the Constitution and Bylaws Board as recommended by the Reference Committee on motion duly made and seconded.

Chapter II, New Section 7:

Add to Chapter II a new Section 7 to read as follows:  
"SECTION 7. LOCAL ARRANGEMENTS COMMITTEE. As soon as practicable following the close of each Annual Session the component societies which will act as host at any later Annual Session shall elect Local Arrangements Committees which shall recommend suitable meeting places and shall have general charge of all local arrangements subject to the approval of Council."

*COUNCIL ACTION—Recommend adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter II, New Section 7—Local Arrangements Committee: The Committee recommends adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted Chapter II, New Section 7 as proposed by the Constitution and Bylaws Board and recommended by the Reference Committee on motion duly made and seconded.

### **CHAPTER III. House of Delegates**

**SECTION 6.** The following shall be the general order of business at all meetings of the House of Delegates: 1. call to order by the Speaker; 2. roll call; 3. election of Speaker and Vice-Speaker (every third year at second session of House of Delegates during Annual Session); their terms of office to begin with adjournment of the House of Delegates; provided a Speaker and Vice-Speaker be elected as the next order of business after the adoption of this Bylaw; 4. reading and adoption of minutes; 5. reports of officers; 6. reports of committees; 7. unfinished business; and 8. new business.

At any meeting, the House by majority vote may change the order of business. New business may be introduced at the final meeting of the House of Delegates only when such business is of an emergency nature or introduced by unanimous consent.

Chapter III, Section 6:

Renumber the present 6th order of business as 7, 7 as 8, 8 as 9, and add a new 6 to read as follows:

"6. election of officers of Association, Delegates and alternates to American Medical Association, and Councilors and Vice-Councilors, if any";  
so that said Section 6, as amended, will read as follows:

"SECTION 6. The following shall be the general order of business at all meetings of the House of Delegates: 1. call to order by the Speaker; 2. roll call; 3. election of Speaker and Vice-Speaker (every third year at second session of House of Delegates during Annual Session); their terms of office to begin with adjournment of the House of Delegates; 4. reading and adoption of minutes; 5. reports of officers; 6. election of officers of Association, Delegates and alternates to American Medical Association, and Councilors and Vice-Councilors, if any; 7. reports of committees; 8. unfinished business; and 9. new business.

"At any meeting, the House by majority vote may change the order of business. New business may be introduced at the final meeting of the House of Delegates only when such

business is of an emergency nature or introduced by unanimous consent."

*COUNCIL ACTION—Recommend against adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter III, Section 6—House of Delegates: The Committee recommended against adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted the recommendation of the Reference Committee in disapproving the proposed change in Chapter III, Section 6 made by the Constitution and Bylaws Board and concurs with the position of Council.

### **CHAPTER IV. Council**

**SECTION 1. COMPOSITION.** The Council is composed of the President, the President-Elect, the Immediate Past President, who shall serve as a full member of Council for a period of three years, two Vice-Presidents, Secretary, Speaker of the House of Delegates or Vice-Speaker of the House of Delegates and one Councilor or Vice-Councilor from each Councilor District. Component County Medical Societies having one hundred or more active members shall be entitled to have one Councilor and one Vice-Councilor directly representing that society. When any component County Medical Society has an active membership of 400, such component Society shall have the privilege of nominating a second Councilor and Vice-Councilor directly representing that Society. In the event that any component County Society attains an active membership of 1,000 such Society shall then have the privilege of nominating a third Councilor and Vice-Councilor directly representing that Society. In any district where there is a component County Medical Society having 100 or more members and there are not at least 50 other members in good standing in the remainder of the district, then just one Councilor and Vice-Councilor shall be nominated to represent the district at large and no nominations shall be made by such component County Medical Society with 100 or more members. In any district where there are two or more component County Societies, each having 100 or more members, then the Society with the largest membership shall nominate a Councilor and Vice-Councilor to represent such Society and no other component Society in the district shall be entitled to do so until such time as there would be a minimum of 50 members in good standing in the remainder of the district. In nominating such Councilor and Vice-Councilor only members of the component county medical society involved shall be allowed to vote and in those districts which contain the large county medical societies having 100 or more active members, only those members residing in the district outside the large county medical society may vote for the Councilor and Vice-Councilor representing that district. Vice-Councilors shall be ex-officio members of Council without the right to vote except in the absence of their respective Councilors when they shall serve as Councilors. The Vice-Speaker shall be an ex-officio member of Council without the right to vote except in the absence of the Speaker when he shall serve in the speaker's stead. Delegates to the AMA, the Treasurer, Editor of the *Journal* and the Executive Secretary shall be ex-officio members of Council without the right to vote.

Chapter IV, Section 1:

Amend Chapter IV by striking Section 1 in its entirety and by substituting in lieu thereof the following Section 1:

"SECTION 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President who shall serve as a full member of Council for a period of 3 years, two Vice-Presidents, Secretary, Speaker of the House of Delegates or Vice-Speaker of the House of Delegates and Councilors or Vice-Councilors selected as follows:

"Subject to the provisions of subsequent paragraphs of this Section, component county medical societies having the number of active members indicated in the following table shall be entitled to have the indicated numbers of Councilors and Vice-Councilors directly representing such societies:



# Pro-Banthine<sup>®</sup>

## (propantheline bromide)

Intragastric photography has provided a new and precise method of measuring the effectiveness of anticholinergic drugs. The transition from gastric motor activity to relaxation seen with effective doses of such drugs takes only a few seconds and is easily demonstrated.

The importance of vagal stimulation of gastric hyperacidity and hypermotility makes such measurements particularly important in evaluating the parasympatholytic effect of drugs used in patients with peptic ulcer, gastritis, biliary dyskinesia and other gastrointestinal disorders.

Pro-Banthine has been shown<sup>1</sup> to produce complete gastric motor inactivity with doses of 6 to 8 mg. intravenously. Comparison tests were made with the belladonna fraction, atropine. Measured usual dosage unit versus usual dosage unit, Pro-Banthine was more than four times as effective as the belladonna alkaloid.

**Indications:** Peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

**Oral Dosage:** Adequate dosage should be given for optimal results. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

**Side Effects and Contraindications:** Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. Pro-Banthine is contraindicated in patients with glaucoma, severe cardiac disease and prostatic hypertrophy.

1. Barowsky, H.; Greene, L., and Paulo, D.: Cinegastroscopic Observations on the Effect of Anticholinergic and Related Drugs on Gastric and Pyloric Motor Activity, *Amer. J. Dig. Dis.* 10:506-513 (June) 1965.

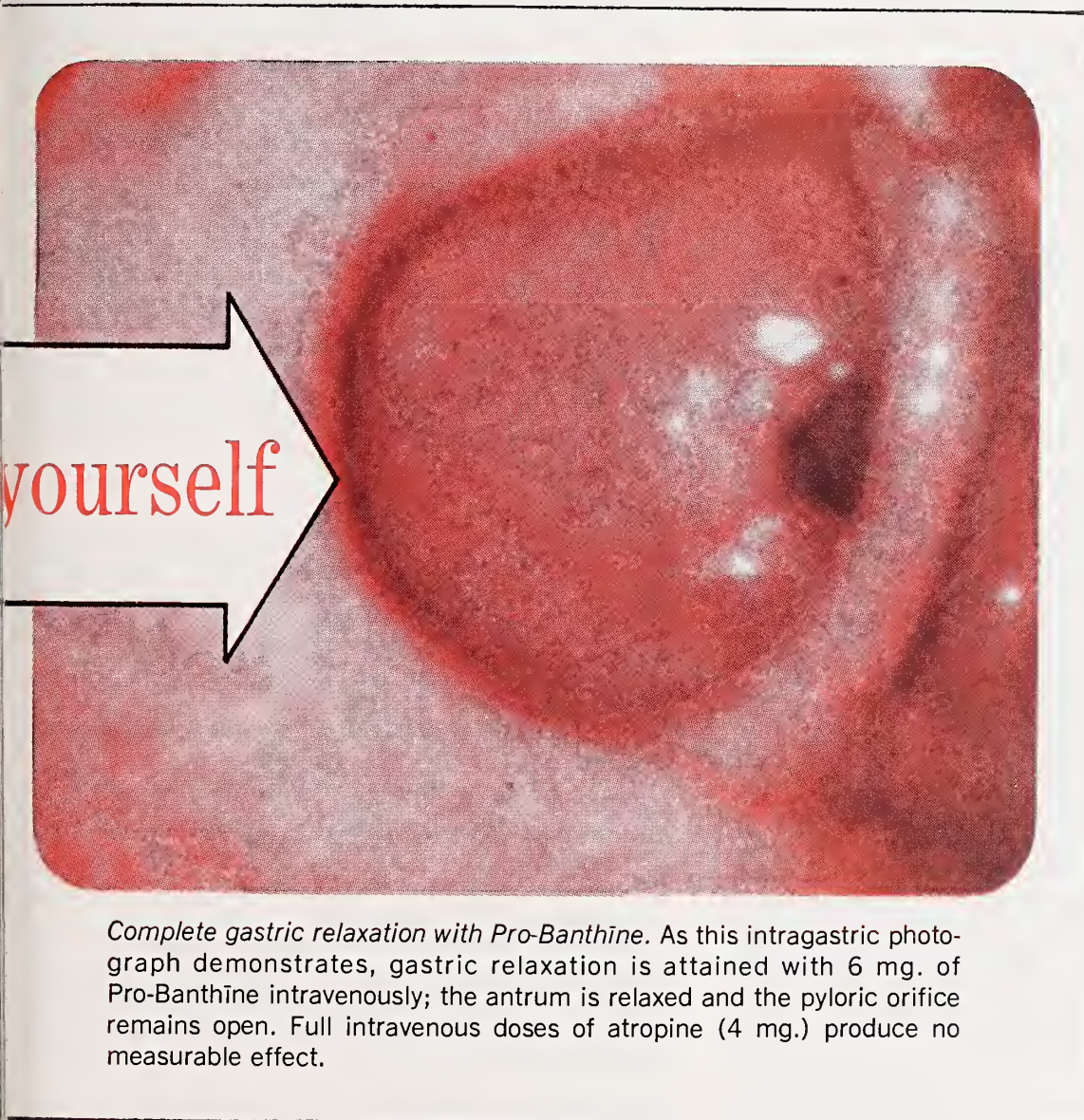
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# Is Effective



yourself

*Complete gastric relaxation with Pro-Banthine. As this intragastric photograph demonstrates, gastric relaxation is attained with 6 mg. of Pro-Banthine intravenously; the antrum is relaxed and the pyloric orifice remains open. Full intravenous doses of atropine (4 mg.) produce no measurable effect.*

**SEARLE**

*Research in the Service of Medicine*



Number of Active Members	Number of Councilors and Vice-Councilors
100 or more	1
400 or more	2
1,000 or more	3

"Each Councilor District having within its limits no component county medical society having separate representation as above stated shall be entitled to have one Councilor and one Vice-Councilor to be elected by the members of the District Society.

"Each Councilor District having within its limit one component county medical society having separate representation as above stated but also more than 50 members not members of the component county medical society having such separate representation shall be entitled to one Councilor and one Vice-Councilor to be elected by all of the members of the District Society not members of the component county medical society having separate representation.

"If a Councilor District has within its limits one component county medical society entitled to separate representation as above stated and less than 50 members of the District Society not also members of the component county medical society having separate representation, then the component county medical society shall have the right to one Councilor and one Vice-Councilor less than the number above provided and such District Society shall be entitled to one Councilor and one Vice-Councilor to be elected by all members of the District Society including the members of the component county medical society having separate representation.

"If a Councilor District has within its limits two or more component county medical societies entitled to separate representation as above stated and there are more than 50 members of the District Society who are not also members of component county medical societies having separate representation as above provide, then the component county medical societies within such district shall be entitled to the number of Councilors and Vice-Councilors above provided and the District Society shall be entitled to one Councilor and one Vice-Councilor to be elected by the members of the District Society who are not also members of any one of the component county medical societies having separate representation as above provided.

"If a Councilor District has within its limits two or more component county medical societies entitled to separate representation as above stated but there are less than 50 members of the District Society who are not also members of a component county medical society entitled to separate representation as above stated, then each component county medical society except the component county medical society entitled to separate representation having the smallest number of active members shall be entitled to the number of Councilors and Vice-Councilors above provided, the smallest component county medical society entitled to separate representation as above provided shall be entitled to one Councilor and one Vice-Councilor less than the number otherwise above provided and the District Society shall be entitled to one Councilor and one Vice-Councilor to be elected by all members of the District Society not also members of the component county medical societies entitled to separate representation except the members of the smallest such component county medical society entitled to separate representation.

"Vice-Councilors shall be ex-officio members of Council without the right to vote except in the absence of their respective Councilors when they shall serve as Councilors. The Vice-Speaker shall be an ex-officio member of Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. Delegates to the American Medical Association, the Treasurer, the Editor of the *Journal*, and the Executive Secretary shall be ex-officio members of Council without the right to vote."

*COUNCIL ACTION—Recommend adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter IV, Section 1—Council Composition: The Committee recommended adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted the proposed change in Chapter IV, Section 1 made by the Con-

stitution and Bylaws Board as recommended by the Reference Committee on motion duly made and seconded.

**SECTION 3. EXECUTIVE COMMITTEE.** The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past President, the First Vice-President, the Secretary, the Chairman of Council, who shall serve as Vice-Chairman of the Committee, and the Chairman of the Council Committee on Finance. It shall meet monthly between the meetings of Council. At any duly called meeting of this Committee for which proper notice has been given, any three (3) members of the Committee shall constitute a quorum. The Committee shall make recommendations to the Council and shall carry out such items of business as are referred to it. The Executive Committee shall appoint all Association Boards and Committees, including Chairmen, and shall nominate members for all Boards required by the laws of the State of Georgia on recommendation of the district societies where applicable; not otherwise provided for, subject to confirmation by Council, and shall serve as Publications Committee of the *Journal*. The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association. The Executive Committee shall be empowered to select an Executive Secretary who shall be responsible to the Executive Committee for his action and for the operation of the Headquarters Office, subject to the approval of Council. The Executive Committee between meetings of Council shall have the authority and power of Council in the field of legislative activity. The Executive Committee shall act as a Board of Trustees directing the Executive Secretary in carrying out the mandates and policies of the Council and the House of Delegates. Between meetings of the Executive Committee, the Chairman of the Executive Committee of Council or his duly appointed representative shall direct the Executive Secretary as to undetermined matters of policy.

Chapter IV, Section 3:

Amend Chapter IV, Section 3, by striking the third sentence now reading "It shall meet monthly between the meetings of Council.", and inserting in lieu thereof two sentences to read as follows:

"The 2nd Vice-President shall be an ex-officio, non-voting member of the Executive Committee. The Executive Committee shall meet monthly between meetings of Council."

*COUNCIL ACTION—Recommend adoption as changed and shown below:*

Chapter IV, Section 3:

Amend Chapter IV, Section 3, by striking the third sentence now reading "It shall meet monthly between the meetings of Council.", and inserting in lieu thereof two sentences to read as follows:

"The 2nd Vice-President and the Speaker of the House of Delegates or in his absence, the Vice-Speaker, shall be ex-officio, non-voting members of the Executive Committee. The Executive Committee shall meet monthly between meetings of Council."

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter IV, Section 3 (first recommendation)—Executive Committee: The Committee recommended adoption of this change as amended by the Council shown in italic type above.

**HOUSE OF DELEGATES ACTION—**Adopted the recommendation of the Reference Committee in approving the Council amendment to the proposed change by the Constitution and Bylaws Board. The Council amendment approved by the House is as follows:

Chapter IV, Section 3: Amend Chapter IV, Section 3, by striking the third sentence now reading, "It shall meet monthly between the meetings of Council.", and inserting in lieu thereof two sentences to read as follows:

"The 2nd Vice-President and the Speaker of the House of Delegates or in his absence, the Vice-Speaker, shall be ex-officio, non-voting members of the Executive Commit-



tee. The Executive Committee shall meet monthly between meetings of Council."

Chapter IV, Section 3, is further amended by striking the third from last sentence reading "The Executive Committee between meetings of Council shall have the authority and power of Council in the field of legislative activity.", and by inserting in lieu thereof the following sentence:

"The Executive Committee between meetings of Council shall have the authority and power of Council except for expenditure of unbudgeted funds in excess of \$1,000.00."

*COUNCIL ACTION—Recommend against adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter IV, Section 3 (second recommendation): The Committee recommended against adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted the recommendation of the Reference Committee in disapproving the second recommendation on Chapter IV, Section 3 as proposed by the Constitution and Bylaws Board and concurs with the position of Council.

**SECTION 4. MEETINGS.** The Council shall meet at the close of the Annual Session to organize and at intervals of not more than four months until the next Annual Session. Special meetings of the Council may be held on the call of the President or upon the request of three members of Council. Regular meeting of Council will be held on call of the Chairman.

Chapter IV, Section 4:

Amend Chapter IV, Section 4, by changing the word "four" in the third line before the word "months" to read "three," so that said Section, as amended, will read as follows:

"SECTION 4. MEETINGS. The Council shall meet at the close of the Annual Session to organize and at intervals of not more than three months until the next Annual Session. Special meetings of the Council may be held on the call of the President or upon the request of three members of Council. Regular meetings of Council will be held on call of the Chairman."

*COUNCIL ACTION—Recommend against adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter IV, Section 4—Meetings: The Committee recommended against adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted the recommendation of the Reference Committee in disapproving the change in Chapter IV, Section 4 recommended by the Constitution and Bylaws Board and concurs with the position of Council.

**SECTION 7. BOARD OF CENSORS.** The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members whether in relation to other members, to the component societies or to the Association referred to it by the Association's Professional Conduct Committee. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association or upon the request of the party concerned on which an appeal is taken from the decision of the Association's Professional Conduct Committee. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society or the Association's Professional Conduct Committee. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

Chapter IV, Section 7:

Amend Chapter IV, Section 7, by deleting it in its entirety and by inserting in lieu thereof the following Section 7:

"7. BOARD OF CENSORS. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members whether in relation to other members, to the component societies, or to the Association as well as all questions com-

ing before it pursuant to the provisions of Chapter IX, Section 4 of these Bylaws. The decision of Council with respect to any matter considered by it pursuant to Chapter IX, Section 4 of these Bylaws, shall be final. Its decision in all other cases shall be final subject to approval of the House of Delegates."

*COUNCIL ACTION—Recommend adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter IV, Section 7—Board of Censors: The Committee recommended adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted the change in Chapter IV, Section 7 proposed by the Constitution and Bylaws Board as recommended by the Reference Committee on motion duly made and seconded.

## CHAPTER V.

### Election of Officers

**SECTION 1. ELECTION.** The President-Elect, the Second Vice-President, Secretary, Councilors, and Vice-Councilors shall be elected by ballot by the members of the Association during the Annual Session. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. The Speaker of the House of Delegates and Vice-Speaker of the House of Delegates shall be elected by members of the House of Delegates and shall serve for a term of three years. Other officers shall be elected for terms of one year each except the Secretary, Councilors, and Vice-Councilors who shall serve for three years. No member shall hold the office of Secretary or Speaker more than two consecutive terms. One-third of the Councilors and Vice-Councilors shall be elected annually.

**SECTION 2. NOMINATIONS.** Nominations for these officers except the Speaker and Vice-Speaker and the Councilors and Vice-Councilors shall be made orally from the floor as the last order of business at the first general session of the Annual Session and no nominating or seconding speech shall exceed two minutes. Nominations for Speaker and Vice-Speaker shall be made by members of the House of Delegates orally on the floor of the House of Delegates as provided in the House of Delegates order of business. Nomination for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the Annual Session. If no nomination is presented by a district society in this manner, nominations shall be made from the floor.

Nominations from those county medical societies having 100 or more active members which are entitled to elect one Councilor and one Vice-Councilor directly representing that society shall be forwarded in like manner as a district society for election by ballot by the members of the Association during the Annual Session.

If a Councilor dies, resigns, or is unable to fill effectively the office of Councilor because of physical incapacity, he shall be succeeded in such office until the next Annual Session by the Vice-Councilor of the District Society or the component County Medical Society which nominated him. If a Vice-Councilor dies, resigns, or is unable to fill effectively the office of Vice-Councilor because of physical incapacity, or is serving as Councilor pursuant to the provision of the immediately preceding sentence of this section, until the next Annual Session, the person to fill the vacancy so created shall be the President, Vice-President, or Secretary in that order of succession, of the District Society or the component County Medical Society which nominated the Vice-Councilor whose office is being filled, provided that if the first such officer in the order of succession is already serving as Councilor or declines to serve, then the next succeeding officer in the line of succession shall serve as Vice-Councilor until the next Annual Session. Both the new Councilor and Vice-Councilor shall only serve until the next Annual Session, at which time nominations from the District Society or the component County Society will be presented for election to fill out the balance of the term for which the original Councilor, or Vice-Councilor was elected. Such interim nominations shall be forwarded in like manner as regular nominations for Councilor and Vice-Councilor.



**SECTION 3. METHOD.** The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

**SECTION 4. TIME.** Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the Annual Session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

**SECTION 5.** Delegates and alternates to the American Medical Association shall be elected in the same manner and at the same time and in accordance with the Constitution and Bylaws of the American Medical Association.

#### Chapter V:

Amend Chapter V by striking it in its entirety and by inserting in lieu thereof the following:

#### "CHAPTER V.

#### "Election of Officers

"**SECTION 1. ELECTION.** The President-Elect, the Second Vice-President, Secretary, and Delegates and alternates to the American Medical Association shall be elected by ballot by the members of the House of Delegates during the Annual Session. Councilors and Vice-Councilors with respect to whom notice of election has not been forwarded by the Secretary of the electing society to the Secretary of the Association not later than fifteen (15) days before the Annual Session shall be elected by ballot by the members of the House of Delegates during the Annual Session. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. The Speaker of the House of Delegates and Vice-Speaker of the House of Delegates shall be elected by members of the House of Delegates and shall serve for a term of three (3) years. Other officers shall be elected for terms of one year each except the Secretary, Councilors, and Vice-Councilors who shall serve for three years. No member shall hold the office of Secretary or Speaker more than two consecutive terms.

"**SECTION 2. NOMINATIONS.** Nominations for President-Elect, Second Vice-President, Secretary, Delegates and alternates to the American Medical Association, Speaker and Vice-Speaker, and Councilors and Vice-Councilors with respect to whom notice of election has not been forwarded by the Secretary of the electing society to the Secretary of the Association not later than fifteen (15) days before the Annual Session shall be made by members of the House of Delegates orally on the floor of the House of Delegates as provided in the House of Delegates order of business.

"The terms of Councilors and Vice-Councilors shall be staggered in accordance with arrangements approved by Council so that as nearly as possible one-third of the Councilors and Vice-Councilors shall be elected each year.

"District societies and component county medical societies entitled to direct representation by one or more Councilors and Vice-Councilors shall, in appropriate years according to the terms of their respective Councilors and Vice-Councilors, elect Councilors and Vice-Councilors at their annual meetings. The Secretaries of such societies shall forward to the Secretary of the Association not later than fifteen (15) days before the Annual Session written notice of such election. In the absence of timely notice of election of a particular Councilor or Vice-Councilor, nominations and elections of such Councilors or Vice-Councilors shall be made by the House of Delegates at the Annual Session provided that the House of Delegates shall only nominate and elect persons to such offices who are members of the society which otherwise would have elected such Councilors and Vice-Councilors.

"If a Councilor dies, resigns, or is unable to fill effectively the office of Councilor because of physical incapacity, he shall be succeeded in such office until the next Annual Session by the Vice-Councilor of the district society or the component county medical society which he represents. If a Vice-Councilor dies, resigns, or is unable to fill effectively the office of Vice-Councilor because of physical incapacity, or is serving as Councilor pursuant to the provisions of the immediately preceding sentence of this section, until the next Annual Session, the person to fill the vacancy so created shall be the President, Vice-President, or Secretary in that order of succession, of the district society or the component county medical society which the Vice-Councilor whose office is being filled represented, provided that if the first such officer in the order of succession is already serving as Councilor or declines to serve, then the next succeeding officer in line of succession shall serve as Vice-Councilor until the next Annual Session. Both the new Councilor and Vice-Councilor shall only serve until the next Annual Session at which time notice of election from the district society or the component county medical society will be presented to fill out the balance of the term for which the original Councilor or Vice-Councilor was elected. Such interim notices of election shall be forwarded in like manner as regular notices of election for Councilor and Vice-Councilor. In the absence of such timely notices of election such interim elections for the balance of such terms shall be filled by the House of Delegates at the Annual Session.

"**SECTION 3.** Delegates and alternates to the American Medical Association shall be elected in accordance with the Constitution and By-laws of the American Medical Association."

*COUNCIL ACTION—Recommend against adoption but recommend instead the following changes in Chapter V:*

#### *Chapter V, Section 2:*

*Amend Chapter V by striking Section 2 thereof in its entirety and inserting in lieu thereof the following Section 2:*

"**SECTION 2. NOMINATIONS.** Nominations for President Elect, Second Vice President, Secretary, Delegates and alternates to the American Medical Association, and Councilors and Vice-Councilors with respect to who notice of election has not been forwarded by the Secretary of the electing society to the Secretary of the Association not later than fifteen (15) days before the Annual Session shall be made by members of the Association orally from the floor as the last order of business at the first general session of the Annual Session and no nominating or seconding speech shall exceed two minutes. Nominations for Speaker and Vice Speaker shall be made by members of the House of Delegates orally on the floor of the House of Delegates as provided in the House of Delegates order of business.

"The terms of Councilors and Vice-Councilors shall be staggered in accordance with arrangements approved by Council so that as nearly as possible one-third of the Councilors and Vice-Councilors shall be elected each year.

"District societies and component county medical societies entitled to direct representation by one or more Councilors and Vice-Councilors shall, in appropriate years according to the terms of their respective Councilors and Vice-Councilors, elect Councilors and Vice-Councilors at their annual meetings. The Secretaries of such societies shall forward to the Secretary of the Association not later than fifteen (15) days before the Annual Session written notice of such election. In the absence of timely notice of election of a particular Councilor or Vice-Councilor, nominations and elections of such



*Councilors or Vice-Councilors shall be made by the members of the Association at the Annual Session provided that the persons nominated and elected to such offices shall be members of the society which otherwise would have elected such Councilors and Vice-Councilors.*

*"If a Councilor dies, resigns, or is unable to fill effectively the office of Councilor because of physical incapacity, he shall be succeeded in such office until the next Annual Session by the Vice-Councilor of the district society or the component county medical society which he represents. If a Vice-Councilor dies, resigns, or is unable to fill effectively the office of Vice-Councilor because of physical incapacity, or is serving as Councilor pursuant to the provisions of the immediately preceding sentence of this section, until the next Annual Session, the person to fill the vacancy so created shall be the President, Vice-President, or Secretary in that order of succession, of the district society or the component county medical society which the Vice-Councilor whose office is being filled represented, provided that if the first such officer in the order of succession is already serving as Councilor or declines to serve, then the next succeeding officer in line of succession shall serve as Vice-Councilor until the next Annual Session. Both the new Councilor and Vice-Councilor shall only serve until the next Annual Session at which time notice of election from the district society or the component county medical society will be presented to fill out the balance of the term for which the original Councilor or Vice-Councilor was elected. Such interim notices of election shall be forwarded in like manner as regular notices of election for Councilor and Vice-Councilor. In the absence of such timely notices of election such interim elections for the balance of such terms shall be filled by the members of the Association at the Annual Session.*

#### *Chapter V, Section 4:*

*Amend Chapter V by deleting Section 4 in its entirety and by inserting in lieu thereof the following Section 4:*

*"SECTION 4. TIME. Voting shall take place during the Annual Session at times set by the Council."*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter V—Election of Officers: The Committee recommended against adoption of the changes proposed in this Chapter by the Constitution and Bylaws Board. It recommended adoption of the changes proposed by the Council in this Chapter, and further recommended appointment of a committee of the House of Delegates by the Speaker of the House of Delegates to study this Chapter, with particular view to the feasibility and mechanics of a mail ballot. The number and composition of this Committee is at the Speaker's discretion and will report to the House of Delegates at the next Annual Session.

**HOUSE OF DELEGATES ACTION—**Adopted the recommendation of the Reference Committee in disapproving the proposal of the Constitution and Bylaws Board in amending Chapter V and approving the changes in Chapter V as recommended by the Council (shown in italics above) according to the action of the Reference Committee on motion duly made and seconded.

## **CHAPTER VI.**

### **Rights and Duties of Officers**

**SECTION 1. PRESIDENT.** The President shall (A) preside at all general meetings of the Association; (B) report to a general session of the Annual Session; (C) assist the Councilors in improving the county and district societies as far as practicable; (D) serve as a member of Council and as

Chairman of the Executive Committee; (E) serve as a member of all committees of the Association with the authority to call a meeting of any board or committee when necessity demands it or after failure of the chairman to do so. With the approval of Council, he may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned to him; and (F) he shall be an ex-officio member of the House of Delegates without the right to vote.

#### **Chapter VI, Section 1:**

Amend Chapter VI, Section 1, by deleting the words "board or" in the eighth line thereof, so that said Section 1, as amended, will read as follows:

**"SECTION 1. PRESIDENT.** The President shall (A) preside at all general meetings of the Association; (B) report to a general session of the Annual Session; (C) assist the Councilors in improving the county and district societies as far as practicable; (D) serve as a member of Council and as Chairman of the Executive Committee; (E) serve as a member of all committees of the Association with the authority to call a meeting of any committee when necessity demands it or after failure of the chairman to do so. With the approval of Council, he may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned to him; and (F) he shall be an ex-officio member of the House of Delegates without the right to vote."

#### *COUNCIL ACTION—Recommend adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter VI, Section 1—President: The Committee recommended adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted the changes in Chapter VI, Section 1 as proposed by the Constitution and Bylaws Board and recommended by the Reference Committee on motion duly made and seconded.

**SECTION 3. THE VICE-PRESIDENTS.** The Vice-Presidents shall be members of the Council. The Vice-Presidents shall assist the President in the discharge of his duties. The 1st Vice-President shall be a voting member of the Executive Committee, and shall attend all meetings. If he is unable to attend any meeting of the Executive Committee, the 2nd Vice-President shall be notified to attend in his stead. Upon request or in the absence of the President, the Vice-Presidents will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or, inability to serve, the Vice-Presidents in their order shall succeed him for the unexpired term. The Vice-Presidents shall be ex-officio members of the House of Delegates without the right to vote. The 2nd Vice-President shall succeed to the office of 1st Vice-President upon the occasion of succession of the President-Elect to the office of President.

#### **Chapter VI, Section 3:**

Amend Chapter VI, Section 3, by deleting the third sentence thereof, reading "If he is unable to attend any meeting of the Executive Committee, the 2nd Vice-President shall be notified to attend in his stead.", and by inserting in lieu thereof the following sentence:

*"In his own right the 2nd Vice-President shall be an ex-officio member of Executive Committee without the right to vote except in the absence of the 1st Vice-President."*

#### *COUNCIL ACTION—Recommend adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter VI, Section 3—The Vice-Presidents: The Committee recommended adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted the changes proposed by the Constitution and Bylaws Board in Chapter VI, Section 3 as recommended by the Reference Committee on motion duly made and seconded.



## CHAPTER VII.

### Component County Societies

**SECTION 10. DISTRICT SOCIETIES.** District societies shall have one or more meetings during the year and shall nominate a Councilor and Vice-Councilor as provided in these Bylaws. These district societies shall be organized for the best interests of the medical profession in Georgia and shall not necessarily conform with the boundaries of congressional districts. District societies shall elect officers, adopt a constitution and bylaws in conformity with the Constitution and Bylaws of the Medical Association of Georgia and levy dues for the government of its own affairs.

#### Chapter VII, Section 10:

Amend Chapter VII, Section 10, by adding at the end of said Section the following sentence:

"In cases where a component county medical society substantially covers the same territory as a Councilor District, no district society need be organized and all references in these By-laws to 'district societies' shall refer as to district society functions to such component county medical societies."

*COUNCIL ACTION—Recommend adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter VII, Section 10—District Societies: The Committee recommended adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted the changes proposed by the Constitution and Bylaws Board in Chapter VII, Section 10 as recommended by the Reference Committee on motion duly made and seconded.

## CHAPTER IX.

### Committees

**SECTION 1.** The Committees of the Associations shall be as follows:

- (A) Executive Committee of Council
- (B) Committee on Finance
- (C) Committee on Professional Conduct
- (D) Committee on Woman's Auxiliary

#### SECTION 2.

- (A) Executive Committee of Council (See Chapter IV., Section 3)
- (B) Committee on Finance (See Chapter IV., Section 9)
- (C) Committee on Professional Conduct

The Committee on Professional Conduct shall consist of the five most recent living Past Presidents of the Association. The senior member shall be chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of the Medical Association of Georgia. All complaints or accusations against any member of the Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigations of a member, shall become the concern of this committee. Complaints may be made by an individual patient, physician, board of censors of any local medical society, attorney, or any officer of a regularly constituted court of law. Upon receipt of notice of such complaint, the committee, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if the committee is convinced that there is sufficient justification for a hearing the physician shall be requested to appear before at least three members of said committee to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged only at such hearing. No member of this committee shall sit in a hearing involving a physician from his councilor district.

After deliberation, the committee shall have a choice of one of the four following dispositions:

- (1) Dismiss the case because of insufficient grounds for a legitimate complaint.

- (2) Attempt a satisfactory adjudication of the complaint.
- (3) Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.
- (4) Refer to the Council of The Medical Association of Georgia all cases in which action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of the Medical Association of Georgia.

Nothing in this Bylaw shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

#### (D) Committee on Woman's Auxiliary.

The Committee on the Woman's Auxiliary shall cooperate with, advise, and direct the Auxiliary in all matters concerning the Association.

**SECTION 3. SPECIAL COMMITTEES AND LIAISON APPOINTMENTS.** Special Committees may be created at any time when the necessity arises. Their necessity must be approved by the Council and they shall be appointed by the President. Special Committees shall be appointed annually and the term of office shall run concurrent with that of the appointing President.

Members of Association serving as liaison representatives of Association on joint committees with other organizations shall be appointed by the President with the approval of the Executive Committee and shall report back at least once a year to the Council.

#### Chapter IX:

Amend Chapter IX by deleting said Chapter in its entirety and by inserting in lieu thereof the following:

## "CHAPTER IX.

### "Committees

**"SECTION 1. STANDING COMMITTEES.** The standing committees of the Association shall be as follows:

- "(A) Executive Committee of Council
- "(B) Committee on Finance
- "(C) Committee on Professional Conduct
- "(D) Committee on Woman's Auxiliary
- "(E) Committee on Constitution and By-laws
- "(F) Committee on Annual Session

**"SECTION 2. EXECUTIVE COMMITTEE OF COUNCIL.** (See Chapter IV., Section 3.)

**"SECTION 3. COMMITTEE ON FINANCE.** (See Chapter IV, Section 9.)

**"SECTION 4. COMMITTEE ON PROFESSIONAL CONDUCT.** The Committee on Professional Conduct shall consist of one member from each of the Association's Councilor Districts of the State, appointed by the Executive Committee of Council. Terms of office shall be for three (3) years and shall be initially staggered so as to provide for the appointment of approximately one-third of the Committee annually. The Executive Committee of Council shall appoint the Chairman of the Committee on Professional Conduct who shall be a member of the Committee and serve for one year and until his successor is appointed. No member of this committee shall serve more than three terms.

"The Committee on Professional Conduct shall investigate all complaints submitted in writing against any member of The Medical Association of Georgia. A 'complaint' subject to investigation by the Committee on Professional Conduct shall be a writing signed by a patient, guardian of a patient, member of the patient's family, or any person having financial responsibility for the support of a patient, or by another member of the Association, or any public official of municipal, county, state or United States Government alleging that the member against whom the complaint is filed is guilty of unethical or illegal behavior against a patient or society indicating that such member should be disciplined, received by the Association or the Committee on Professional Conduct as follows:

- "(1) On appeal from action by the component county medical society by either the complainant or the member against whom the complaint is lodged:



- "(2) On referral from a component county medical society when such society or its Committee on Professional Conduct by whatever name called requests that the Association assume original jurisdiction of the matter in behalf of the county society; or
- "(3) On direct appeal by the complainant when the component county medical society having original jurisdiction has not commenced investigation within ninety (90) days after receipt of the complaint.

"The Association and the Committee on Professional Conduct shall have no jurisdiction of a complaint which merely seeks compensation from or criticism of a member for malpractice not constituting unethical or illegal behavior. All other complaints or statements of charges received in writing by the Association shall be referred to the component county medical society of which the member against whom the complaint is made is a member. When a complaint is forwarded to the component county medical society having original jurisdiction, a copy of such complaint shall also be sent to the member against whom the complaint is lodged and the complainant shall be notified of such action.

"The Committee on Professional Conduct, upon receipt of a complaint which comes under its jurisdiction as previously set forth, shall send a copy of the complaint, by registered or certified mail with return receipt requested, to the member against whom the complaint is lodged. The member shall be notified at that time that he has thirty (30) days after his receipt of the complaint to file a written answer to the complaint with the Committee. The member shall also be notified that if he fails to file a written answer to the allegations in the complaint within the thirty (30) day period, the Committee may consider the allegations to be admitted.

"Within sixty (60) days after receipt by the Committee of the written answer from the physician against whom the complaint was lodged, or, if the member against whom the complaint has been lodged does not respond within the thirty (30) day period, the Committee will either:

- "(1) dismiss the case because of insufficient grounds to substantiate a legitimate complaint, notifying both parties of this decision; or
- "(2) convene a hearing, notifying both parties in writing, by registered or certified mail with return receipt requested, of the hearing at least fifteen (15) days in advance of such hearing.

"Attendance at such hearings shall be limited to members of the Committee, MAG Staff and legal counsel assigned to assist the Committee; witnesses, if any; the complainant and his legal counsel, if any; and the member against whom the complaint has been lodged and his legal counsel, if any. Parties, their counsel, Committee members, and Staff may call and cross-examine witnesses, introduce evidence reasonably germane to the issues, and enter objections to testimony and material offered in evidence. The Committee shall not be bound by the rules of evidence usually employed in legal proceedings but may accept any evidence they deem appropriate and pertinent. Should any party to the controversy fail to appear at the hearing, the Committee may, at its discretion, continue, dismiss, or proceed with the hearing. A majority of all members of the Committee on Professional Conduct in office shall constitute a quorum for the transaction of business of the Committee and action may be taken upon the vote of a majority of Committee members present at any meeting at which a quorum is present. The Committee may designate three or more members to constitute hearing officers at the hearings on complaints specified herein.

"At the conclusion of the hearing, or the hearing officer's report, the Committee shall meet with the legal counsel and necessary staff assigned to assist the committee in closed session and render a report in writing containing its findings and conclusions and recommendations, if any to the Council of the Medical Association of Georgia. All parties of record and their legal counsel shall be notified that a report has been submitted to the Council of the Medical Association of Georgia for their action. The Committee on Professional Conduct in its deliberations shall have a choice of one of the four following dispositions:

- "(1) Dismiss the case because of insufficient grounds for a legitimate complaint as defined above;
- "(2) Attempt a satisfactory reconciliation of the parties involved;

- "(3) Suggest to the member changes in his conduct and relationship with his patients;
- "(4) Refer to Council of The Medical Association of Georgia all cases in which action by Council is deemed necessary with the recommendations of the Committee as to disciplinary actions to be taken by the Council of The Medical Association of Georgia. The Committee may recommend, and Council may take (whether or not recommended by the Committee on Professional Conduct) any one or more of the following actions:

- "(a) Dismiss the complaint;
- "(b) Censure the member in writing by registered or certified mail, return receipt requested, and notify all other parties of record and their counsel of such action;
- "(c) Censure the member before the Committee on Professional Conduct at a meeting, notice of which has been given by registered or certified mail, return receipt requested, to parties of record and their legal counsel;
- "(d) Suspend the member from membership in the Association without refund of dues for a period certain not to exceed one year; or
- "(e) Expel the member from membership in the Association without refund of dues. Expelled members shall not be entitled to reinstatement to membership until two (2) years from the date of expulsion and only upon favorable recommendation of the county medical society.
- "(f) Notification of any action of Council of the Medical Association of Georgia under items (a), (d) and (e) above shall be sent by registered or certified mail, return receipt requested, to all parties of record and legal counsel.

"Any disciplinary action of a member by Council shall only affect the members' standing in the Medical Association of Georgia. A written report of such disciplinary action shall be made to the secretary of the component county medical society of which the disciplined member is a member but such member's standing in his component county medical society shall not be affected thereby but only pursuant to action of the component county medical society according to its constitution and by-laws.

"SECTION 5. COMMITTEE ON WOMAN'S AUXILIARY. The Committee on Woman's Auxiliary shall cooperate with, advise, and direct the Auxiliary in all matters concerning the Association.

"SECTION 6. COMMITTEE ON CONSTITUTION AND BY-LAWS. The Committee on Constitution and By-laws shall be responsible for the continuing study of the organization of The Medical Association of Georgia. It shall recommend to the House of Delegates, through Council, any amendments or revisions which seem necessary or advisable. At least every five (5) years the Committee on Constitution and By-laws shall recommend revisions after a complete study of the organization of the Association and its Constitution and By-laws. Proposed amendments shall be referred to the Committee on Constitution and By-laws for recommendation before action thereon is taken by the House of Delegates.

"SECTION 7. COMMITTEE ON ANNUAL SESSION. The Committee on Annual Session shall carry out the approved policies of the Association as directed by Council. It shall study and make recommendations concerning the Annual Sessions of the Association. The Committee shall submit a budget for the Annual Session to the Finance Committee of the Association."

#### *COUNCIL ACTION—Recommend adoption.*

REFERENCE COMMITTEE RECOMMENDATION—Chapter IX—Committees: The Committee recommended adoption of this change.

HOUSE OF DELEGATES ACTION—Adopted the changes proposed by the Constitution and Bylaws Board in Chapter IX as recommended by the Reference Committee on motion duly made and seconded.



## CHAPTER X.

### Boards

**SECTION 1.** The Boards of the Association shall be as follows:

- (A) Medical Education
- (B) Hospital Activities
- (C) Governmental Medical Services
- (D) Volunteer Health Agencies
- (E) Occupational Health
- (F) Interprofessional Relations
- (G) Public Service
- (H) Legislation
- (I) Insurance and Economics
- (J) Constitution and Bylaws
- (K) Annual Session
- (L) Special Activities

(The remainder of Chapter X is an explanation of the duties and functions of the Boards of the Association and due to its length is not printed here.)

#### Chapter X:

Amend Chapter X by deleting it in its entirety and by inserting in lieu thereof the following:

### "CHAPTER X.

#### "Special Committees

"SECTION 1. Special committees as required for the conduct of the business of the Association shall be instituted, and members thereof appointed, by Council of the Association with or without the recommendation of the Executive Committee of Council, by the Executive Committee of Council, or by the House of Delegates of the Association. The House of Delegates may instruct Council to institute, and appoint members, to particular special committees. The number of members of each special committee and the method of their appointment shall be specified in the resolution instituting the particular special committee. Unless other provisions of these By-laws or of the Constitution of the Association require, all committee appointments shall be made on an annual basis until the meeting of the particular appointing authority coinciding with or next following the next Annual Session of the Association. All special committees shall report to the House of Delegates annually for disposition at the Annual Session. The Council of the Association shall review all Committee reports prior to the Annual Session and shall have authority to make such recommendations thereon as it wishes."

*COUNCIL ACTION—Recommend adoption.*

**REFERENCE COMMITTEE RECOMMENDATION—**Chapter X—Special Committees: The Committee recommended adoption of this change.

**HOUSE OF DELEGATES ACTION—**Adopted the changes proposed by the Constitution and Bylaws Board in Chapter X as recommended by the Reference Committee on motion duly made and seconded.

## Supplemental Report of the President No. A

### MAG MEDICAL ETHICS CONFERENCE

GEORGE H. ALEXANDER, M.D., *President*

Since the report of the President to the House of Delegates of necessity had to be written prior to March 5, this supplemental report concerns the AMA's First National Conference on Medical Ethics held in Chicago, March 5-6, 1966.

This conference was outstanding in its format and in the speakers who made presentations. The workshops held and the reports from the different workshops pinpointed many of the problems which we have been having and will continue to have to face from a standpoint of ethics and the law.

I would like to recommend that a similar conference be held during the coming year by the Medical Association of Georgia and would further suggest that, if possible, some of the AMA speakers be asked to participate on our program. I have some names I would like to turn over to whomever puts on the program in order that they might be invited to be guests at our conference.

I would like to further recommend that the State Medical Examiners be invited to participate in this program.

**REFERENCE COMMITTEE RECOMMENDATION—**Supplemental Report No. A—MAG Medical Ethics Conference: The Committee recommended adoption of this supplemental report.

**HOUSE OF DELEGATES ACTION—**Adopted Supplemental Report of the President No. A: Medical Ethics Conference as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Reference Committee No. 3 Secretary J. Watts Lipscomb, Forest Park, and duly seconded that the report of the Reference Committee be approved as a whole and it was so ordered.

## Report of Reference Committee No. 4

Roy Gibson, Columbus, Chairman

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)*

Reference Committee No. 4 met in Room No. 324, of the Ralston Motor Hotel, Columbus, Georgia, at 2:30 p.m., May 9, 1966. Members present were: Roy Gibson, Columbus, Chairman; Irving D. Hellinga, Toccoa, Secretary; Spencer Brewer, Atlanta; R. A. Acree, Hahira; and Julius Johnson, Augusta.

### Muscogee County Medical Society Councilor

LUTHER H. WOLFF, M.D., *Columbus*

The Councilor of the Muscogee County Medical Society considers it an honor and privilege to have served his County Society during the past year. All meetings of the Council except one were attended. Reports of Council activities were given to the County Society at intervals during the past year.

The officers and members of the Muscogee County Medical Society have been working enthusiastically and hard to make the Annual Meeting of the Medical Association of Georgia a rewarding and pleasant one for the year 1966.

This Councilor has heard faint grumblings that the Annual Meeting had been reduced to such a height of efficiency that there was no longer time for having any fun at the Annual Meeting. Whether or not the Annual Meeting should be prolonged to the former three and one-half day level or retained at the present two and one-half day level is something a reference committee might wish to consider.



Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Muscogee				
E. M. Molnar				
Columbus . . . . .	124	108	114	100

**REFERENCE COMMITTEE RECOMMENDATION**—The report of the Muscogee County Medical Society Councilor was approved with commendation. The Reference Committee concurs with the decision of the Annual Session Committee to arrange plans for a two and one half day session.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Muscogee County Medical Society Councilor with the additional recommendation by the Reference Committee in concurrence with the decision of the Annual Session Committee to arrange plans for a two and one half day Annual Session on motion duly made and seconded.

### Richmond County Councilor

H. D. PINSON, M.D., *Augusta*

During the past year, I have attended all of the council meetings except one, when I was providentially hindered. I have served on the Negotiating Committee as a representative from the Georgia Chapter of the American College of Surgeons. I feel that this committee, which was created by the House of Delegates at the 1965 MAG annual session, is making some progress in their work.

I would like to suggest that a special effort be made to stimulate interest in attendance at our future annual sessions in order to reverse the downward trend in attendance that has been prevalent for the past several years.

Counties and Secretaries	Members December 31, 1965		Members December 31, 1964	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Richmond				
Stuart H. Prather, Jr.				
Augusta . . . . .	251	220	247	215

**REFERENCE COMMITTEE RECOMMENDATION**—This report was approved by the Reference Committee with the following recommendation for sequence of meeting sites. This recommendation is made on the basis of a continued need to stimulate attendance at our Annual Session and in consideration of financial returns incumbent upon selection of the meeting sites. The Reference Committee recommends that the cities of Atlanta, Augusta and Savannah be utilized in rotation as sites for our Annual Session.

**HOUSE OF DELEGATES ACTION**—Vice-Speaker Rogers recognized Thomas Goodwin, of Augusta, who spoke in opposition to the Reference Committee recommendation concerning the rotation of sites for the MAG Annual Session. Vice-Speaker Rogers also recognized Lamar Peacock, of Atlanta, who also spoke in opposition to the Reference Committee recommendation on the selection of sites, and who moved to amend the Reference Committee report as follows:

“That the Annual meeting be held only in cities offering facilities which allow all meetings to be held in one building or facility.”

This motion was duly seconded.  
Vice-Speaker Rogers recognized Luther Wolff, of Columbus, who spoke in opposition to both the amendment and the Reference Committee’s recommendation. Vice-Speaker Rogers recognized Henry Tift, of Macon, who spoke in opposition to the amendment and the Reference Committee’s recommendation. Also recognized by Vice-Speaker Rogers was Addison Simpson, Washington, who spoke against the amendment.

Vice-Speaker Rogers then recognized Joseph Christmas, Vienna, who moved to amend the amendment, by deleting the part pertaining to “buildings.” The Christmas motion was duly seconded.

The Vice-Speaker then recognized William Moore, of Atlanta, who proposed the following substitute motion, which was duly seconded: That the third sentence of the Reference Committee report reading, “The Reference Committee recommends that the cities of Atlanta, Augusta and Savannah be utilized in rotation as sites for our Annual Session” be deleted from the Reference Committee report. The question was called, and the substitute motion was approved.

The House then adopted the Reference Committee recommendation as amended as follows: “This report was approved by the Reference Committee with the following recommendation for the sequence of meeting sites. This recommendation is made on the basis of a continued need to stimulate attendance at our Annual Session and in consideration of financial returns incumbent upon selection of meeting sites.”

### Richmond County Vice Councilor

J. L. MULHERIN, M.D., *Augusta*

The following is my report as Vice Councilor of the Richmond County Medical Society:

During the past year, your Vice Councilor has attended all the meetings of Council. At the June Council meeting, I was appointed by Council to contact the chairman of the State Board of Health, Dr. John M. Martin, in an effort to get his approval to make it mandatory that physicians be represented on all Area-Wide Hospital Planning Councils. Dr. Martin was contacted and through his efforts the policies of the State Board of Health were so changed.

I also served as chairman of a committee, appointed by Council, to study Area-Wide Hospital Planning Councils. Others on this committee were Dr. Milford Hatcher and Dr. Napier Burson. This committee met in Macon, Ga. in October 1965, and plans were made to have a conference on “Area-Wide Hospital and Health Planning” on January 16, 1966 in Macon. Invitations were sent to each county medical society requesting that they send one or two of their officers to the meeting. Due to a poor response this conference was cancelled after all the arrangements had been made.

All of the above proceedings were done on the suggestions of the May 1965 House of Delegates.

**REFERENCE COMMITTEE RECOMMENDATION**—This report was approved by the Reference Committee.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Richmond County Medical Society Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

### Annual Session

THOMAS Q. SPITZER, M.D., *Chairman*

Plans were made for the forthcoming Annual Session at Columbus, Georgia.

This year all of the speciality societies were given an opportunity to meet alone if they so desired. For the first time the entire Association will meet together for a socio-economic and scientific program sponsored by MAG.

The above changes were made in hopes of increasing attendance.

**REFERENCE COMMITTEE RECOMMENDATION**—This report was approved and commendation given to the Chairman of the Annual Session Board and his Board members.



**HOUSE OF DELEGATES ACTION**—Adopted the report of the Annual Session Board as recommended by the Reference Committee on motion duly made and seconded.

## Governmental Medical Services

LUTHER H. WOLFF, M.D., *Chairman*

A called meeting of the Board of Governmental Medical Services was held at the Headquarters Building of the Medical Association of Georgia at ten o'clock on November 21, 1965. Present were Drs. W. Bruce Schaefer, J. C. Thoroughman, Eugene L. Griffin, L. E. Dickey, Jr., and Luther H. Wolff.

After the Chairman called the meeting to order, a prolonged discussion ensued regarding the payment of physicians for services rendered individuals under governmental sponsored and financed programs. There was thorough agreement that a usual and customary charge for such services rendered should be made to the governmental agencies for the services so rendered. It was recommended that the Chairmen of the Subcommittees of Governmental Medical Services work in co-ordination with the special fee schedule committee appointed by Dr. Alexander so that uniformity in fee schedules would exist. Also it was urged that each Subcommittee Chairman make recommendations for per diem payment schedules for work done in government sponsored clinics.

A detailed report of the activities of the various Subcommittees present was then given by Drs. Griffin, Dickey, and Schaefer.

The Board of Governmental Medical Services recommends to the House of Delegates that each Subcommittee of Governmental Medical Services be authorized and urged to draw up a reasonable and customary fee schedule, not only for specific purposes rendered but also for work done in the various government sponsored clinics.

**REFERENCE COMMITTEE RECOMMENDATION**—The report of the Reference Committee approved the report of the Governmental Medical Services Board with the exception of the mid-portion of paragraph two which is changed to read: "It was recommended that the Chairman of the Board of Governmental Medical Services work in co-ordination with the special fee schedule committee appointed pursuant to the action of the House of Delegates of 1965," omitting the portion "so that uniformity in fee schedule would exist"; the Reference Committee also recommends that the substance of the recommendations in paragraph four be handled in the course of deliberations of the Fee Negotiating Committee of MAG, since this Committee is by its very nature in a position to state the prescribed fees within the various specialty groups and the Georgia Academy of General Practice.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Governmental Medical Services Board as amended by the Reference Committee on motion duly made and seconded.

## Crippled Children Subcommittee

L. E. DICKEY, M.D., *Chairman*

At the request of Dr. Dixon A. Lackey, Jr., Medical Director of the State of Georgia Crippled Children's Service, an Ad Hoc Committee on Guidelines for Crippled Children was appointed.

The committee was appointed because of increasing difficulties experienced by Dr. Lackey in selecting those conditions which can best be rehabilitated and which

are amenable to therapy from an ever growing list of medical problems seen at the clinics. Present eligible categories as listed by the Crippled Children's Service are rather vague, and the Service desires that a committee from the medical community afford some guidance in future plans.

The committee met at MAG Headquarters in Atlanta on Saturday, February 26, 1966, and the problem was discussed in detail. Members of the committee present included: L. E. Dickey, Jr., Macon, Chairman; Thomas L. Ross, Macon; H. Harlan Stone, Atlanta; Edwin C. Pound, Jr., Atlanta; Martin Smith, Gainesville; and David Williams, Augusta. Also present were Dr. Lackey, Dr. Morris E. Brackett, and Dr. Fred Allman, State Board of Health. Mr. M. D. Krueger, MAG Headquarters Office Staff was also present.

It was mutually concluded that the Crippled Children's Service would establish what they considered to be an acceptable list of conditions on the basis of our discussion, and submit this list to appropriate members of the committee for further suggestions. Further committee meetings are contingent upon the result of editing of this list. It seemed generally to be felt that the committee has served a worthwhile purpose to this point and a satisfactory solution to the problem is anticipated.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approves the report and commends the Chairman for his efforts.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Crippled Children Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

## Blood Banks Subcommittee

MENARD IHNEN, M.D., *Chairman*

The Subcommittee on Blood Banks has considered the following topics: uniform standards for blood banks, regulation of blood bank services by the State Health Department, and interchange of blood among hospitals in Georgia. Information was exchanged throughout the year. A telephone conference was held on 21 February 66; all members of the committee participated.

The Subcommittee on Blood Banks believes that there is a need for uniform minimum standards which should be applied to all medical facilities which provide blood for transfusion. We recommend that the standards of the American Association of Blood Banks be accepted by the State Health Department and by the Georgia Hospital Medical Council as minimum standards. We suggest that all blood banks providing blood for transfusion should meet these standards within one year. Voluntary participation in regulatory programs is preferred to licensure by a state agency. However, we emphasize that it is essential that these standards be in effect to protect public welfare.

With respect to interchange of blood, the Subcommittee suggests that implementation of a program of minimum standards for all blood banks will accomplish much to facilitate interchange of blood. For this reason, major emphasis should be placed on the program of proper standards.

To meet these standards, it may be necessary for hospitals to give more support to physician and technical personnel responsible for transfusion services.



**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approves this report and asks that the recommendations of its Chairman be given consideration by the agencies mentioned, namely the State Health Department and the Georgia Hospital-Medical Council. The Reference Committee feels that Blood Banking standards must be uniformly statewide and that the standards of the American Association of Blood Banks should be accepted.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Blood Bank Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

**Interprofessional Relations**

WILLIAM C. COLES, M.D., *Chairman*

The Medical Association of Georgia's members of the Interprofessional Council of Georgia were active participants in the organization's activities throughout the year. C. Daniel Cabaniss, one of the physician members, was elected Chairman of the Council for 1966.

The activities of the Council were dominated by the dissemination of information between the several professions regarding federal legislation relating to the health fields and the implementation of these new laws.

Through the medium of the Council the Medical Association effectively elicited support of the allied professions in certain State legislative matters. This organization also served as an effective sounding board and liaison agent for other lesser matters of general interest to the medical, dental, veterinary medical and pharmacy professions.

**REFERENCE COMMITTEE RECOMMENDATION**—The report is approved by the Reference Committee and its work is commended.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Interprofessional Relations Board as recommended by the Reference Committee on motion duly made and seconded.

**Legislation**

J. FRANK WALKER, M.D., *Chairman* of Board and Subcommittee on National Legislation  
HARRISON L. ROGERS, JR., M.D., *Chairman* Subcommittee on State Legislation

During the past 12 months your Legislative Board has continued its efforts to promote the best interest of the medical profession in Georgia at both the national and state levels. It has been an eventful 12 months since the last annual report of this Board was given: The Congress has enacted so-called "medicare" and the Georgia General Assembly has completed its annual 40 day session at the State Capitol.

During this period the entire legislative setup (Board and both Subcommittees) has been reorganized with a view toward reducing the size of the Board and its Subcommittees for State and National Legislation. Prior to reorganization the Board and its Subcommittees had grown to such proportions that it became administratively burdensome; quick decisions, as are so often required, had become near impossible.

In essence, the reorganization reduced the Board to five members and the Subcommittees to three members each. The same members of the Board also serve on its Subcommittees. Members of the Board were selected and appointed by Council to accomplish four objectives: liaison with the AMA Legislative Council, direct inside

contact with the Georgia General Assembly, MAG Executive Committee representation, and a good personal working relationship with a member of the Georgia Congressional delegation.

**NATIONAL LEGISLATIVE ACTIVITY**

The enactment of so-called "medicare" dominated the Federal legislative picture during the 1965 term of the Congress. Prior to enactment your Board directed its efforts toward (1) defeat of this bill, and (2) amendments to make the bill more livable. In the area of amendments to the bill MAG was successful along with others in defeating efforts to designate the services of hospital based physicians (radiology, pathology, anesthesiology) as hospital services. The National Legislative Subcommittee also sponsored two personal visits to Washington for the purpose of contacting Senators Russell and Talmadge relative to this bill.

Another bill of much concern to MAG was the Heart Disease, Cancer and Stroke Amendments of 1965—legislation based on the recommendations of the so-called DeBaKey Commission. Due to the intensive efforts of the AMA and of physicians representing your National Legislative Subcommittee, this bill was ultimately amended many times and, in essence, improved the character of the bill considerably. MAG was never able to support this bill, even after extensive amendments were made because the bill introduced to the system of medical practice some revolutionary, far reaching and potentially dangerous concepts. However, our efforts were successful in that the bill was greatly improved before enactment.

The 1965 annual MAG Congressional Luncheon was held as usual at the Capitol, in Washington, and was reported to the House of Delegates at the last session. As of the time this report is being prepared, the 1966 Congressional Luncheon is tentatively scheduled for early April. The customary format will probably be observed; that is, one physician from each Congressional District will make this trip as the personal host to his Congressman for this annual event.

**STATE LEGISLATIVE ACTIVITY**

The 1966 session of the Georgia General Assembly was one of the most active from a medical legislative point of view to be held in many years. There were more than 50 bills and resolutions of significant concern to MAG. In addition, we were dealing with a reapportioned legislative body in which many of the members were serving their first term. To this extent, we were dealing with many unknown quantities with no history of support or opposition to medically oriented legislation.

Once again, the Georgia Podiatry Association sponsored legislation to compel Blue Shield coverage for services offered by podiatrists to all Blue Shield policyholders. After a hectic week during which this bill was reported from the House Insurance Committee and placed on the House General Calendar, it was defeated on the floor; 54 votes for passage and 101 votes against passage. The osteopaths once again came forth with their "full practice privilege" bill. However, their bill failed to attract sufficient support in the House Hygiene and Sanitation Committee and consequently was never reported to the full House for a vote.

A long sought MAG objective, namely statutory approval for voluntary sterilization, was enacted. Also, on



the positive side of the ledger was an MAG sponsored bill to require a year's internship as a condition to full licensure. Both of these bills were introduced and managed by Dr. Charles B. Watkins, of Ellijay, one of the four physician members of the House of Representatives.

Other bills in which MAG had an interest and concern were: compulsory testing for phenylketonuria (passed); home health care services to be provided by local Boards of Health (passed); creation of an autonomous Board of Mental Health (failed); release of research data without liability (passed); two year nurse training program (passed); family planning (passed); dangerous drug regulatory bill (passed); mental health interstate compact (failed); family responsibility to pay state institutions for treatment (passed); fluoridation (failed); grants to medical facilities (passed); pay off medical scholarship loans with service at State institutions (passed); osteopathic internship (passed); void existing naturopath licenses (failed); and creation of interim committee to investigate Blue Shield (failed).

## COMMENDATIONS

Your Subcommittee for State Legislation is indebted to many physicians over the State for their assistance in the passage of and the defeat of many of the bills introduced at the 1966 session of the General Assembly. We would like to particularly acknowledge their assistance in support of passage of the voluntary sterilization and one year internship bills and for their tireless efforts to help defeat the podiatry and osteopathic bills. Without their help it is doubtful if we could have been successful in any one of these four areas.

The Subcommittee would also like to acknowledge the debt that medicine in Georgia owes to four physicians who voluntarily took 40 days out of their practice to serve in the Georgia House of Representatives. These physicians were: Charles B. Watkins, Ellijay; Frank P. Holder, Jr., Eastman; Carl Savage, Montezuma; and A. S. Johnson, Elberton. Their professional sacrifice to serve the cause of good government is the personification of citizenship and your Board, together with its Subcommittee for State Legislation, wishes to thank them and commends their efforts to the entire Association.

## RECOMMENDATIONS

Your Board, in consultation with both of its Subcommittees, makes the following recommendations for consideration by the House of Delegates:

(1) That the annual Congressional Luncheon be continued at the discretion of the Board irrespective of whether or not there is a pending legislative crisis at the national level. Your Board makes this recommendation with the view that the annual Washington trip is our best means of maintaining and improving relations with our State Congressional delegation.

(2) That an annual social-business dinner and/or party be given for certain members of the General Assembly as a means by which rapport with that body may be improved. Such an affair would naturally have to be consistent with budgetary limitations. However, it is the feeling of your Board that expenditures in excess of those allocated in the past would be required.

(3) That each County Medical Society plan to de-

vote one meeting during the fall of the year to a frank discussion of past and proposed legislative matters with their elected members of the General Assembly in the House and Senate, and that the President, Secretary, or their designee communicate with the MAG Headquarters Office the results of such discussions.

(4) That each County Medical Society consider and determine the best ways and means under which total participation in legislative affairs may be achieved on the part of all physicians. The field of legislation has become so complex, so time consuming and so immensely important to the future of the medical profession that the job of legislative contacts, determination of legislative policy and indeed general interest and concern in the broad spectrum of legislative objectives can no longer be handled by a single individual or even by a small group of individuals. We must develop and maintain interest in this area on a broad base. This can only be done when a majority of the physicians of all County Medical Societies help shoulder this responsibility.

(5A) That the House of Delegates and all County Medical Societies give serious attention to the growing need of the medical profession to have increased representation in the Georgia General Assembly. The total membership of the House of Representatives and the Senate is now 259 (Senate 54 and House 205). Of this total, law, farming and insurance have by far the most representatives. Medicine has but four representatives in the House and no one representing medicine in the Senate. The four physician members of the House represent less than two percent of the total membership of the General Assembly. It is crystal clear, therefore, that we must increase our numbers in the House and most particularly the Senate if our best interests are to be fully protected and promoted in the Legislature. Each year the Legislature becomes more and more interested in legislative matters that bear directly on medical practice and the medical practitioner. Good physician candidates must be found and encouraged to run for State House seats.

(5B) As a simple but necessary adjunct to recommendation 5A serious attention should also be given to campaign finances to help those of our members who would agree to actively seek public office in the General Assembly. Such financial support cannot, of course, come from the treasury of the County Medical Society as this would be in violation of the Federal statutes. However, County Medical Societies can and should, with the full blessing of the House of Delegates, encourage their members as individuals to contribute financially to the campaigns of their colleagues. Your Board recommends this in the strongest possible terms.

**REFERENCE COMMITTEE RECOMMENDATION**—The report of the Legislative Board and of the Subcommittees on National Legislation and State Legislation are approved and highly commended. The Reference Committee desires that MAG affirm that the Mental Health Interstate Compact Bill has the support of MAG. The Reference Committee additionally urges that members on the subcommittees and on the Board continue to be vigilant in opposition to undesirable legislation. Finally, the Reference Committee recommends that physicians be alert to opportunities to serve at County and State legislative levels in the interests of the profession and the public.

**HOUSE OF DELEGATES ACTION**—At this point, the Vice-Speaker recognized Julius Johnson, of Augusta, who moved that the last sentence be changed to read: "Finally,



the Reference Committee recommends that physicians be alert to opportunities to serve at County, State and National legislative levels in the interests of the profession and the public." This motion was seconded and adopted.

Vice-Speaker Rogers then recognized Irving Greenberg, of Atlanta, and he moved that the last sentence of the Reference Committee recommendation be changed as follows: "Finally, the Reference Committee recommends that physicians be alert to opportunities to serve at County, State and National legislative levels in the interest of the public and the profession." This motion was seconded and adopted.

The House then adopted the report of the Legislative Board with the additional recommendations of the Reference Committee and the amendments to the Reference Committee's report made by the House.

## Special Activities

JOHN S. ATWATER, M.D., *Chairman*

The Board of Special Activities has continued to work in liaison with the State Board of Medical Education listing physicians and localities seeking placement. This is done through the MAG Physicians' Placement Bureau.

Upon the instruction of Council the Board of Special Activities has instituted a study of the possible use of educational television as a means of continuing education to the physicians of Georgia. There are two facets to the program. The first is in regard to television programs oriented to physicians only. The second has to do with programs of public interest. Such programs could be broadcast over regular television channels or the CATV network. No decision as to the ultimate usefulness of such a program has been made by the Committee at this particular time but the entire program is under study. It is to be emphasized that the Committee was not asked to activate any such program, merely to study its feasibility aiming toward the distant future if any positive action were ever taken.

The Subcommittee on Health Care of the Aging continues its activities. As in the past, members have continued to appear before various civic, social and professional organizations on behalf of the Aging program and the position of medicine in such activity. The Health Care of the Aging Committee has continued its cooperation with other organizations through the Georgia Joint Council to Improve the Health Care of the Aged. At the spring meeting of the Georgia Joint Council it was felt that there should still remain liaison between the various members of the Council, but that most of the activities now were overlapping with other Committees and Boards of the various organizations represented. It is therefore, recommended that the Joint Council as a Council be abolished and instead, a committee be substituted. This committee is only to meet when problems arise that have joint interests to the respective member organizations (Medical Association of Georgia, Georgia Nursing Home Association, Georgia Hospital Association, and Georgia Dental Association).

It is hoped that the continued efforts of this Subcommittee and Board will produce an even greater awareness of the problems facing the private practice of medicine. It is recommended that the Medical Association of Georgia continue its support of the work of this Board and Subcommittee.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approves the report of the Special Activities Board and commends the Chairman.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Special Activities Board as recommended by the Reference Committee on motion duly made and seconded.

## Voluntary Health Agencies

PAUL T. SCOGGINS, M.D., *Chairman*

Chairman attended Voluntary Health meeting of AMA at Chicago, February 16-17, 1966 and reported to Council. The Committee will meet as soon as AMA sends complete record and proceedings to the Chairman.

**REFERENCE COMMITTEE RECOMMENDATION**—The report of the Chairman was approved with the additional recommendation that the Voluntary Health Agencies Board be kept intact and further exploited in its efforts to coordinate these diverse agencies.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Voluntary Health Agencies Board with the additional recommendations made by the Reference Committee on motion duly made and seconded.

## Late Report No. 3

### SCHOOL CHILD HEALTH SUBCOMMITTEE

JACK HUGHSTON, *Chairman*

This Committee has continued during the past year to follow through on projects which had earlier been initiated and also to instigate studies in several new areas:

#### I. Follow-up on existing projects.

A. Smoking and Health, Teacher Resource Kits have been prepared and the State Department of Education has agreed to distribute these kits to directors of curriculum, libraries and other selected public school outlets. The Georgia Heart Association, The Georgia Tuberculosis Association, The Georgia Cancer Society, and the State Health Department have participated in the joint planning and coordination of this project.

Appropriate pre-test and post-test questionnaires to measure the effectiveness of the project have been included and will be evaluated and reported.

The Committee feels that this is a very worthwhile project in the light of the evidence relating cigarette smoking to certain health hazards. Further, the Committee feels that since this resource has the sanction and support of the State Curriculum Supervisor, it will receive wide-spread utilization.

B. This Committee, following the recommendations of the House of Delegates of the American Medical Association and those of the American Association for Health, Physical Education and Recreation, and believing that physical education in schools and colleges should be an integral and basic part of such educational institutions, has continued to make recommendations and undertake studies of the ways and means of implementing compulsory physical education in Georgia Public Schools. An important step in realizing this goal was taken this year when the Georgia Department of Education named Mr. Wilbur



Stanley as Consultant. The need for State level leadership in physical education and health education has been recognized by this Committee and had been reported to the Georgia Department of Education.

- C. The Medical Association of Georgia, through this Committee again sponsored a postgraduate course on "The Medical Aspects of Sports." Physicians, coaches and trainers who were in attendance heard from outstanding authorities on medical problems in relation to athletics. Dr. Richard Schneider, Neurosurgeon and Dr. Robert W. Bailey, Orthopedic Surgeon, both members of the faculty of the University of Michigan Medical School spoke on head and neck injuries and shoulder injuries. Other problems discussed included medical restrictions in athletics; rules, standards and protective equipment; nutrition for athletes; ankle injuries; heat adaptation in athletics; and Marine Corps fitness and circuit training.

The Committee was disappointed in the attendance and therefore has undertaken a study to determine whether or not another date would be more beneficial. Any change would not be effective however until 1967. The 1966 meeting will be held on Thursday afternoon, August 4, in conjunction with the Georgia High School Coaches Association and the High School Allstar game.

## II. Future Projects.

- A. Cosponsor along with the Department of Education and the Department of Public Health a seminar on physical fitness for the grade schools of Georgia.
- B. To study methods and means to meet the need of youth to have access to accurate information on crucial problems such as drug addiction, use of alcohol, sex education, venereal disease, and ways of implementing effective health education.
- C. To compile athletic standards for acceptable sports programs at various levels of school or community recreation programs.

There are social, psychological, and physiological reasons for developing the best kinds of physical education programs for all children in schools, supplemented by good, well supervised intramural sports and recreational activities.

**REFERENCE COMMITTEE RECOMMENDATION—**  
This report was approved and the Chairman commended for his current and prospective program.

**HOUSE OF DELEGATES ACTION—**Adopted Late Report No. 3: School Child Health Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

## Supplemental Report of Council No. B

### AUTONOMOUS DIVISION OF MENTAL HEALTH

CHARLES R. ANDREWS, M.D., *Chairman*

During the recent (1966) session of the Georgia General Assembly legislation was introduced in the Senate (S.B. 21), the effect of which would have been to create a separate, autonomous Division of Mental Health within the Georgia Department of Public Health.

This Division would have operated apart from the Department of Public Health; would have been run by a separate Mental Health Board, and would have been neither administratively nor budget wise responsible to the State Board of Health or the State Department of Public Health.

Among other provisions of this bill, the Mental Health Board and the separate and autonomous Division of Mental Health would have assumed jurisdiction over all present and future State supported mental health facilities in Georgia.

**THIS BILL PASSED THE SENATE BUT WAS KILLED IN THE HOUSE RULES COMMITTEE. IT DID NOT PASS AND DID NOT BECOME LAW.**

MAG went on record in opposition to the enactment of this bill as did the State Board of Health. MAG opposition was based on the belief that to separate mental health from physical health would cause more problems than it would attempt to solve; that it would result in costly duplication of services; that it would tend to take mental health away from medical supervision and place this responsibility more in the hands of lay groups, and would fragment health care in Georgia to such an extent as to retard progress in the field of both mental and physical illness.

Following the defeat of this bill in the House Rules Committee a resolution to create a Mental Health Division Study Committee was passed. The effect of this resolution will be to set up a committee that will make a study of this matter and report back to the General Assembly at its 1967 session. This is a clear indication that the sponsors of this bill will make an effort to have the same bill, or one very similar to it, enacted next year.

The State Board of Health has requested that MAG officially go on record in opposition to the creation of a separate, autonomous Division of Mental Health and that the present Division of Mental Health be retained as a Division of the State Department of Public Health. Accordingly, the Council of the Medical Association of Georgia voted to recommend this position to the MAG House of Delegates with a request that the House similarly endorse this position.

**REFERENCE COMMITTEE RECOMMENDATION—**  
This report was approved without change.

**HOUSE OF DELEGATES ACTION—**Adopted Supplemental Report of Council No. B: Autonomous Division of Mental Health as recommended by the Reference Committee on motion duly made and seconded.

## Resolution No. 3

### PHYSICIAN-PATIENT CONFIDENTIAL RELATIONSHIP

W. W. OSBORNE, *Georgia Medical Society*

WHEREAS, the relationship between physician and patient is such that the element of confidence is essential

J.M.A. GEORGIA



to the full and satisfactory maintenance of the relationship between the parties and is one in which the public would benefit by recognizing that such relationship should come within the protection of the law.

NOW, THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia go on record as favoring the expansion of the present law of Georgia codified in Code Section 38-418 to include within the legal category of confidential communications excluded from consideration of public policy, the communications between physician and patient excepting such as may be released by authority of the patient.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves this Resolution and urges its passage.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 3: Physician-Patient Confidential Relationship as recommended by the Reference Committee on motion duly made and seconded.

**Resolution No. 4**

**MENTAL HEALTH BOARD**

BILLY S. HARDMAN, *Hall County Medical Society*

WHEREAS, significant progress has been made and continues to be made in Georgia in the field of mental Health, this progress in spite of inadequate funds, and

WHEREAS, any approach to the treatment of illness, the whole person must be considered and separation of mental health from physical health, or public health, or community health is neither logical nor desirable, and

WHEREAS, the present structure of the state public health program makes available personnel and facilities which can be utilized in expanding the mental health program in Georgia, and

WHEREAS, separation of control of public agencies for provision of health services to citizens of Georgia will result in confusion, inefficiency, duplication of services, and resultant waste of public money;

THEREFORE, BE IT RESOLVED, that because of the previously mentioned practical and philosophical reasons, the MAG House of Delegates opposes the concept of establishment of a separate board for mental health services in Georgia and also opposes the establishment of an autonomous division for mental health in the structure of the present State Board of Health.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves Resolution No. 4 in opposition to the creation of a separate State Mental Health Board, in the interest of administrative efficiency and coordination of effort.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 4: Mental Health Board as recommended by the Reference Committee on motion duly made and seconded.

**Supplemental Report of Mental Health Subcommittee No. F**

**MENTAL HEALTH**

W. D. STRIBLING, M.D., *Chairman*

WHEREAS, a comprehensive mental health plan for the State of Georgia has been completed and initiated with twin programs of regional mental hospitals and comprehensive community health programs. Implementation of these programs is already underway; and

WHEREAS, recent events at the Milledgeville State Hospital have further emphasized schedule plans for the decentralization of patients at the Milledgeville State Hospital, and;

WHEREAS, treatment of mental illness needs to be within the main stream of medicine, and administrative inefficiency and inadequate patient care would result from any separation of mental health from public health,

THEREFORE, BE IT RESOLVED that the Mental Health Committee of the Medical Association of Georgia offers its full support to the Board of Health, Department of Public Health and the Division of Mental Health in their present form, and opposes creation of a separate Board of Mental Health or Department of Mental Health; and

FURTHER, BE IT RESOLVED that the Mental Health Committee of the Medical Association of Georgia urges the *earliest possible transfer of patients* from the Milledgeville State Hospital to Thomasville and Bainbridge, and the *quickest possible construction of the Mental Retardation Institute and the regional mental hospitals in Atlanta and Augusta*; and the Mental Health Subcommittee further urges the provision of sufficient funds to adequately staff these additional acute psychiatric hospital facilities.

NOTE: This resolution approved by the MAG Council May 7, 1966.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves the Resolution with the exception of deleting the word “acute” in paragraph 5, so that the sentence will read: “and the Mental Health Subcommittee further urges the provision of sufficient funds to adequately staff these additional psychiatric hospital facilities.”

HOUSE OF DELEGATES ACTION—Adopted the Supplementary Report of the Mental Health Subcommittee No. F: Mental Health as amended by the Reference Committee.

At this time, the Vice-Speaker recognized Mr. John Moore, MAG Attorney, who stated that in a previous action by the House, in their consideration of changes in the Constitution and Bylaws, the House voted to establish committees rather than “Boards.” By general agreement, the Vice-Speaker ruled that where the word “Board” appeared in Reference Committee recommendations as adopted by the House, due to the previous action of the House, the word “Committee” would be substituted as necessary.

It was moved by Reference Committee No. 4 Chairman Roy Gibson, Columbus, and duly seconded that the report of Reference Committee No. 4 be approved as amended and it was so ordered.

**Report of Reference Committee No. 5**

John T. Godwin, Atlanta, Chairman

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee’s recommendation and the action to it taken by the House of Delegates.)*

Reference Committee No. 5 met in Room 326, of the Ralston Motor Hotel, Columbus, Georgia, at 2:30 p.m., on May 9, 1966. Members present were: John T. Godwin, Atlanta, Chairman; Charles R. White, Macon, Vice Chairman; T. A. Sappington,



Thomaston, Secretary; M. K. Cureton, LaFayette; Benjamin B. Okel, Decatur; and Frank R. Miller, Thomasville.

## Disaster Medical Care Subcommittee

VIRGIL B. WILLIAMS, M.D., *Chairman*

The Chairman of the committee attended the AMA Seminar on Disaster Medical Care in Chicago in 1965. Information gained at these meetings is most valuable in planning programs of the Subcommittee on Disaster Medical Care.

The committee maintains files on those hospitals which have pledged to furnish Disaster Medical Care Teams to respond when and where needed. Splendid liaison with the State Civil Defense authorities has been maintained. This relationship consists of their pledge to furnish transportation and housing for medical personnel at major disaster scenes.

The Chairman of this committee has attended three meetings with State Department of Health in formulating plans for the Emergency Program in Resources in the field of Disaster Medical Care.

The committee has been ready at all times to assist the local societies in planning Disaster Medical Care Programs. Information concerning Disaster Medical Care programs has been distributed to county societies requesting such.

**REFERENCE COMMITTEE RECOMMENDATION**—The report was received, approved and the Committee commended for its activities.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Disaster Medical Care Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

## Maternal and Infant Welfare Subcommittee

EUGENE L. GRIFFIN, M.D., *Chairman*

Under the chairmanship of Doctor Eugene Griffin, this committee met six times during the calendar year 1965. Two of these meetings were specially called meetings, and the other four were the regular quarterly meetings to review the cases of maternal mortality occurring in the State of Georgia and those residents of the state who expired outside the state in association with childbirth. The Maternal and Infant Welfare Committee studies every case of maternal mortality occurring in Georgia, and sends a critique of the handling of the cases to the physician in attendance at the time. The response to questionnaires is better; however, improvement is needed in giving at least the gross findings at autopsy when done and in giving additional pertinent information in the remarks section since no one questionnaire can be formulated to adequately cover all cases. During the year there were two cases that could not be adequately studied due to lack of response by the attending physician. The physician's and the patient's identity is kept anonymous during the review and the study, even to the members of the committee.

Seventy-two cases were studied that showed on the death certificate any indication where the death might have been associated with a pregnancy. Fifty-seven of these cases reviewed were classifiable as maternal deaths and all but eight of these were classified as direct obstetrical deaths. There were 100,581 live births in

Georgia during 1964, thus giving a maternal death rate per 10,000 live births of 5.7. The rate has dropped steadily in Georgia since 1940 reaching a low of 4.8 per 10,000 live births in 1962, but has increased to 5.7 in 1964.

Fluctuations can be expected on a year to year basis, however, our efforts should be directed toward a continuing decrease. The latest comparative statistics on a state basis revealed Georgia to rank 41st in the nation in maternal death rate. This is an improvement since 1958 at which time Georgia ranked third from the bottom. The primary causes of maternal mortality re-

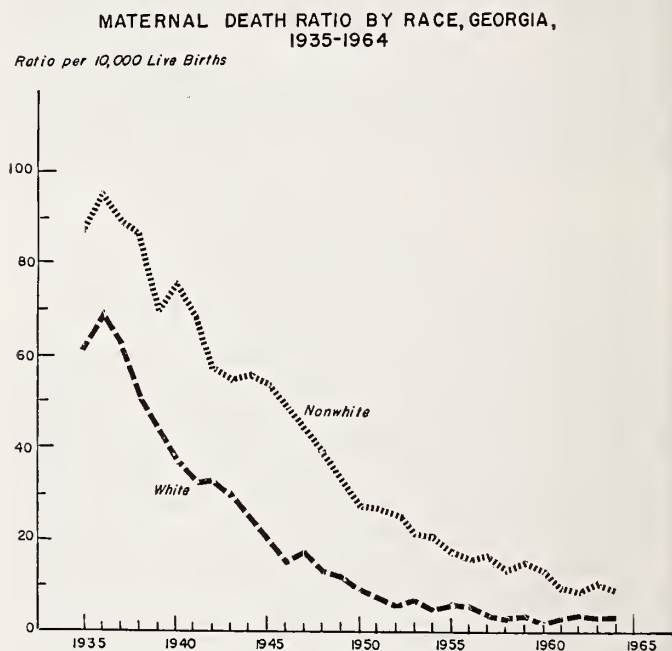


Figure 1

main hemorrhage, toxemia and infection. Fourteen of the maternal deaths were associated with abortion, eight of which were septic. The number of live births per year in Georgia has remained essentially the same since 1954 fluctuating around 100,000 per year.

There were 7,372 live births without a medical attendant for a percentage of 7.3 of the total in 1964. This is of much concern to the committee even though it is an improvement over 1963 both in numbers 7,683 and percentage 7.7. The number of births attended by granny midwives and others has been decreasing continually and persistently over the years in Georgia; however, not nearly as rapidly as it should.

Another matter of concern is the premature rate. It has increased persistently and substantially over the years, for example, in 1947 the rate in Georgia was 60.8 per 1,000 live births and it has risen persistently each year to 95.5 in 1964. The rate in 1963 was 95.3 as compared to the national average of 82 per 1,000 live births.

Last year we were able to report that five additional counties had worked out a plan for delivery by a physician in the hospital of the low income high risk group of the obstetrical patients; however, this year we are able to report only one additional county assuming this responsibility. These plans have been accomplished through diligent efforts and close cooperation of the local physicians, hospitals and the health departments of the community. It is hoped that plans of this type



will be considered by all local medical societies in Georgia. Those plans that have been successful are those in which the local physicians have taken the initiative and leadership.

Live births to unwed mothers continues to rise in Georgia. The rate in 1963 was 100.6 per 1,000 live births as compared to 102.6 in 1964.

The committee also took under consideration, for necessary support and action, other factors related to maternal and infant health and welfare during this period. The Maternal and Infant Care Project co-sponsored by the Richmond County Health Department and the Medical College of Georgia, has progressed well; and, plans are being considered for expanding the program from eleven counties to thirteen counties and also to include expansion further into pediatric and dental care. The Maternal and Infant Project centered at Grady Memorial Hospital in Atlanta covering two counties, became operational and is now functioning well. Basic plans have been developed for another Maternal and Infant Care Project in a rural area of Georgia to include five counties. These Maternal and Infant Care Projects are supported financially by Children's Bureau and the State and Local Health Departments. The committee is intensely desirous that such projects be developed throughout Georgia.

In the last report it was brought out that the committee was cooperating with the Junior Chamber of Commerce, State Health Department, Department of Family and Children Services, Department of Agriculture and the Department of Education in the promoting of surplus food commodities for the needy expectant mothers throughout the state. This has progressed to the extent that the program is being utilized in 38 counties. Five counties in the Appalachian area have included the Food Stamp Program as a part of this effort.

The committee has also supported the programs of family planning and the updating of methods of pregnancy spacing to include the more recent methods that are considered good medical practice. In so doing the committee met with the Executive Committee of Council and the Interprofessional Council on two different occasions. The State Board of Health approved the addition of the intrauterine contraceptive device method and the ovulation suppression method. The utilization of the intrauterine contraceptive device method has been well accepted over the state both by the professional personnel and by the patients. The more expensive materials are being reserved for those who cannot tolerate the intrauterine contraceptive device.

The previously submitted Sterilization Law was reviewed and modified for resubmission to the legal adviser through proper channels for consideration by the next legislature. The committee feels that there is a very urgent need for such legislation. As of the time for submission of this report, the chairman has been informed that this legislation has been passed and awaiting the Governor's signature.

Endeavors in the prevention of mental retardation have been maintained in the sharing of information with the American Medical Association concerning the activities in Georgia in the testing of infants for phenylketonuria. The committee also met with the President of the Georgia Pediatric Association, the President of the Georgia Academy of General Practice, and in cooperation with the President of the Georgia Chapter of the American Academy of Pediatrics, to consider the testing of infants for phenylketonuria on a statewide

basis. In this joint session the committee recommended the testing of infants for phenylketonuria and so sent its recommendations to the Executive Committee of Council.

During the year the committee has supported the establishment of a statewide program of screening for carcinoma of the cervix. Such a program has the support of the Georgia Association of Pathologists and the State Obstetrical and Gynecological Society.

The committee again desired to express its sincere appreciation to the physicians over the state who have cooperated with the committee in the study of the maternal deaths throughout the state by their submission of the completed questionnaires and additional information as indicated. It is only through such cooperation that the committee can function and accomplish its assigned duty.

**REFERENCE COMMITTEE RECOMMENDATION**—Report approved and the Committee commended. Note: The sterilization law, House Bill No. 60 has been signed into law.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Maternal and Infant Welfare Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

## Insurance and Economics

HENRY S. JENNINGS, JR., M.D., *Chairman*

During this year attempts have been made to inform the membership of MAG concerning the Group Insurance Program developed a year or so ago by the work of the Board of Insurance and Economics in conjunction with the Life Insurance Company of Georgia. Several meetings have been held with representatives of the insurance company and subsequently mailings have been made to the entire membership, announcements requested at county medical society meetings, and follow up visits have been made by agents of the insurance company. Up to the present time (March 1, 1966) the number of members expressing a desire to participate in the Group Insurance Program has been disappointing. The reasons for this lack of participation will be evaluated and further meetings with the representatives of the Life Insurance Company of Georgia will be necessary.

The 1965 MAG House of Delegates passed a resolution placing the Association on record as favoring an expansion of insurance coverage for mental illness. This matter was referred to the Board of Insurance and Economics. As a consequence of this a representative of the Georgia Psychiatric Association met with the Board of Insurance and Economics to discuss this problem. In addition to this communications have been exchanged with Mr. James Bentley, Insurance Commissioner, and the Health Insurance Council in Georgia expressing the interest of the MAG in this matter and informing these interested groups that the Board of Insurance and Economics would be extremely happy to work with any groups in order to promote more widespread insurance coverage for mental illness. It would seem from several comments and suggestions that one problem here is that of informing, or educating, the public to the point where coverage for mental illness is requested as part of an insurance contract.

At the request of the Georgia Radiological Society a letter endorsing the resolution of that society concerning the separation of professional fee from tech-



nical services has been sent to all of the insurance carriers in Georgia, this letter stating also that this same opinion was expressed in a resolution passed by the 1965 MAG House of Delegates.

Recently there has been increasing discussion in several parts of the United States, and in Georgia, concerning the "prevailing fee" concept for payment of physicians by Blue Shield. The Board of Insurance and Economics was represented at a meeting in Macon in December concerning this. This meeting was held by one of the committees of the Columbus Blue Shield Plan and representatives of MAG were invited to attend. Subsequent to this, the Council of MAG requested the Board of Insurance and Economics to investigate further the "prevailing fee" concept. At the March meeting of Council the Board of Insurance and Economics recommended that MAG Council take no action on the "prevailing fee" concept but that this matter of endorsing, approving or disapproving of this new idea be left to each county medical society.

## Supplemental Report of Insurance and Economics Board No. D

### PROFESSIONAL LIABILITY INSURANCE

HENRY S. JENNINGS, JR., M.D., *Chairman*

Annually, the Medical Association of Georgia enjoys the privilege of reviewing the past year's experience of Professional Liability Insurance in the State of Georgia as underwritten by the St. Paul Insurance Companies. In a joint meeting convened April 7, 1966, the MAG Insurance and Economics Board and representatives of the St. Paul Insurance Companies reviewed the experience data for the year 1965.

Based on this experience, the St. Paul Insurance Companies recommended no change in the present premium cost structure. The St. Paul representatives also indicated that an additional review of the experience may be necessary after another six months of experience is gained. MAG representatives then approved this "no change" recommendation. Other matters pertinent to the experience data were discussed and explained and the meeting was adjourned without further actions.

**REFERENCE COMMITTEE RECOMMENDATION**—The Insurance and Economics Board report and Supplemental Report No. D were received and the Committee commended. It is noted with delight that there will be no increase in professional liability insurance premiums for the coming year.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Insurance and Economics Board and Supplemental Report No. D: Professional Liability Insurance as recommended by the Reference Committee on motion duly made and seconded.

## Nursing Liaison Subcommittee

J. G. McDANIEL, M.D., *Chairman*

As Chairman of the Nursing Liaison Subcommittee I have met with the Chancellor of the University System and their nursing committee on two occasions. A bill was proposed to legalize a two year associate degree program at junior colleges. This bill was passed by the Legislature and awaits the Governor's signature.

The committee from the Board of Regents, headed by Doctor Harry S. Downs, hopes to commence programs

for nurses in one or two of the junior colleges in the very near future.

I am heartily enthusiastic about this program since all of us are aware of the fact that we are faced with an acute shortage of nurses.

Doctor Charles Eberhart of Atlanta, as the new Chairman of the committee, will carry on other projects of this committee and I have the privilege of remaining on as a member of the committee.

## Supplemental Report of Nursing Liaison Subcommittee No. E

### NURSING ACTIVITIES SURVEY

CHARLES EBERHART, *Chairman*

A survey of MAG membership opinion of Nursing activities revealed that physicians feel strongly that Student Nurses in both Diploma and Baccalaureate Schools of Nursing receive too little experience in bedside nursing and too much academic content; that it is unwise to disassociate these schools from hospitals, and that Graduate nurses are underpaid.

This Committee is concerned over future availability of "Floor and Private Duty Nurses" for employment in general hospitals. It is certain that the nation-wide shortage of Nurses will grow more acute. The same trends, operative since 1946, will prevail in the nursing sphere. During this interval, 30% of Diploma Schools have closed from up-grading their requirements. We believe the pressure in Educational circles to close all diploma schools is in serious error and furthermore, that these circles are making an illogical response to the needs of our time.

### Recommendations:

- 1) That the MAG call attention of the National League of Nursing, The American Nurses Association and the American Hospital Association to the results of this survey;
- 2) That these National Leagues of Nursing consider realignment of the bedside nursing experience—academic ratio of a student nurses' education to a more realistic proportion;
- 3) That Diploma schools of Nursing be preserved; and
- 4) That our AMA Delegates consider introduction of this report at the next AMA meeting or making this study available to AMA for their action.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee considered the Nursing Liaison Subcommittee report and Supplemental Report No. E together. This report was received and approved with editorial changes to substitute under recommendation No. 2 in Supplementary Report No. E to read: "That these nursing organizations consider realignment of the bedside nursing experience—academic ratio of a student nurses' education to a more realistic proportion." The Committee members are commended for this report. We also wish to include the recent statewide survey relating to nursing activity as an addition to this report.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Nursing Liaison Subcommittee and Supplemental Report No. E: Nursing Activities Survey as amended by the Reference Committee and with the additional recommendation of the Reference Committee on motion duly made and seconded.



## Medical Education

THOMAS W. GOODWIN, M.D., *Chairman*

The Medical Association of Georgia Board of Medical Education has spent a year in consolidation, planning, and watching. We have obtained a great deal of satisfaction from the programs which have been initiated in the years gone by. We have seen them progress. The medical school circuit courses, which were to be implemented this year, have proved to be a tremendous success. The cities that were chosen for these courses during this past year are Dalton, Dublin, Moultrie, Thomaston, Toccoa, and Waycross, and in each of these locations six one-day programs were presented by members of the faculty. There were also longer and more intensive courses held at the Medical College of Georgia. It is felt that implementation of these courses has meant a great deal to the medical profession in our state. We have continued to watch the situation insofar as general practice residencies are concerned and see no reason to make any changes in these programs at the present time, since these residencies are still not filled.

The Board of Medical Education has had only two meetings this year, both of which were held in January in Atlanta, the first meeting being a planning session and the second one concerning the educational aspects of Public Law 89-239 (The Heart Disease, Cancer and Stroke Program). In attendance at this second meeting were representatives of the State Department of Public Health, the Georgia Heart Association, the Georgia Division of the American Cancer Society, Georgia Hospital Association, Fulton County Medical Society, Georgia State League for Nursing, Georgia State Nurses Association, Medical Association of Georgia, Medical College of Georgia, Emory University School of Medicine, and the Georgia Dental Association. Mr. Karl D. Yordy of the National Institutes of Health, Bethesda, Maryland, reviewed the general provisions of the law.

The committee decided not to have the workshop similar to the one we had last year at Callaway Gardens on medical education. Instead, it was decided that these meetings should be held every other year.

Let me take this occasion, also, to thank the members of the Medical Education Board for their cooperation and support.

**REFERENCE COMMITTEE RECOMMENDATION**—The report of this Board received, approved and its members are commended.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Medical Education Board as recommended by the Reference Committee on motion duly made and seconded.

### AMA-ERF Subcommittee

BRASWELL COLLINS, M.D., *Chairman*

The AMA Education and Research Foundation is one of the finest activities of our profession.

During the four years of the Foundation's existence it has served primarily to provide loans to medical students, interns, and residents in need of assistance. Each \$1.00 in this fund has guaranteed \$12.50 in bank credit for the Foundation. Loans were granted in Georgia to 193 in 1964 and to 214 in 1965.

More than 10,000 individual physicians gave to the Loan Program in 1965. The Women's Auxiliaries

throughout the country again contributed a significant sum through benefits and special fund raising events. Many companies, foundations, organizations, and individuals have contributed to the Loan Program.

The AMA-ERF will continue this Loan Program and will also sponsor other activities.

The funds for Medical Schools program is an important source of unrestricted money for the operating budget of every American medical school.

The Institute for Biomedical Research has been established in the AMA Headquarters Building. It is a privately supported project financed through AMA-ERF and not the AMA budget. Medical research is the backbone of medical practice and in this Institute the scientists can probe the mysteries of the living cell and the life process without pressure from any one certain industry or government agency.

We ask all members of the profession to contribute to AMA-ERF in which they can take pride.

**REFERENCE COMMITTEE RECOMMENDATION**—The report was received and approved.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the American Medical Association—Education and Research Foundation Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

### Public Service

ROBERT E. WELLS, M.D., *Chairman*

The primary function of the Public Service Board continues to be the presentation of the Annual County Medical Society Leadership Conference which was held this year in Atlanta on February 5 and 6. The attendance at this meeting this year was outstanding and the program was sound.

The Chairman of the Public Service Board has participated also in the deliberations of the Ad-Hoc Committee on Medical Ethics.

This Board stands ready to carry out whatever other public service projects it may be called upon to do, but has not as yet received requests for additional performance.

**REFERENCE COMMITTEE RECOMMENDATION**—Report approved and the Committee commended for the excellence of the annual County Medical Society Leadership Conference held this year.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Public Service Board as recommended by the Reference Committee on motion duly made and seconded.

### Medicine and Religion Subcommittee

W. HARRISON REEVES, M.D., *Chairman*

Our Subcommittee efforts this year were to continue to improve our liaison with the clergy through "keymen" in the component county medical societies. Where the committee has such keymen, we improved existing relationships in greater depth and we also worked in areas where we wished to inaugurate this liaison. Good contacts have now been made in south Georgia.

At our September meeting of the Subcommittee, Dr. Ben Calloway of Brunswick reported on a significant meeting held jointly with the Brunswick Ministerial Association. Under the leadership of Dr. Noah Meadows of Marietta, the activity of the Subcommittee was fur-



ther strengthened by the invitation of lawyers and judges in the area and from the state at large, to participate with clergymen and doctors for a consideration of THE LAW.

We are in hopes that more county medical societies will convene joint society meetings with the clergy on a regular annual basis to further carry out the aims of our Subcommittee. We are adding county society keymen to Subcommittee so that we may effect this liaison.

**REFERENCE COMMITTEE RECOMMENDATION**—Their report was received and approved.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Medicine and Religion Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

## Mental Health Subcommittee

W. D. STRIBLING, M.D. *Chairman*

The Subcommittee on Mental Health has met during the year and formulated plans for a meeting of presidents and secretaries of the county medical societies on the subject of "Community Mental Health Programs." We have run into considerable difficulty in scheduling this meeting because the same presidents and secretaries were attending a MAG county medical society leadership conference in February. It was necessary for us to cancel our proposed meeting at that time, but we were able to have the chairman of our committee placed on the program of the MAG leadership conference and he had the opportunity to explain the Mental Health Subcommittee's objectives as they relate to community mental health programs. We are contemplating holding a leadership conference sometime in the summer of 1966.

The Subcommittee on Mental Health has had splendid cooperation from the President of the Georgia Psychiatric Association. The President of this Association is serving on the Subcommittee and has assured the cooperation of the Georgia Psychiatric Association in the formulating and staffing of community mental health programs.

The year 1966 will see comprehensive community medical programs being established throughout Georgia. These programs are now underway in many areas and will require the full cooperation and leadership of physicians as these programs are set up. We do feel it is important in 1966 that a meeting be held for leadership of county medical societies to better inform and educate this leadership in the art of setting up such programs.

This will conclude our report for 1966. If further information is required please let us know.

**REFERENCE COMMITTEE RECOMMENDATION**—Report approved and the Committee commended for their activities.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Mental Health Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

## Report of the Journal

EDGAR WOODY, JR., M.D., *Editor*

The 1965-66 report of the *Journal of the Medical Association of Georgia* is submitted herewith.

## PERSONNEL

Since our last annual report we have been fortunate to have had no changes in the personnel working with the *Journal*. Our Headquarters Office Staff along with our Contributing Editors have functioned efficiently and have been very helpful in the work of the *Journal*.

## PRINTING

Because of a substantial increase in the cost of printing within the past year it became necessary to obtain competitive bids from several printing firms. As a result of these bids it was decided to contract with The Ovid Bell Press, Inc. of Fulton, Missouri. This firm prints five other medical journals besides our own and all expressed satisfaction with the job done by The Ovid Bell Press. During the six months we have been associated their work has been found to be of high quality and our relations have been most satisfactory.

## COST CONTROL

By continuous balancing of the volume of editorial material with advertising we have been able to remain within our projected budget. Because of slowly increasing advertising revenues we are hoping to balance *Journal* expenditures with income during the coming year. This will mark the first year in the past five years when we could think in such terms.

## STATE MEDICAL JOURNAL ADVERTISING BUREAU

In November of 1965 the Managing Editor and the Editor attended the biennial conference sponsored by the Bureau in Chicago. At this meeting the details of the reorganization of the Bureau were outlined for all participating journals. Question and answer sessions dominated the meeting and all seemed gratified at the progress in sales that has been made since the reorganization less than two years ago. It was a very worthwhile meeting.

## CREDITS

Thanks are due to the Publications Committee whose counsel is frequently sought in matters concerning *Journal* policy. Thanks are also in order for our outgoing president whose cooperation in publication of the monthly President's Page has been invaluable. The editors and contributors of our specialty pages have been most cooperative in supplying good material and their efforts are much appreciated.

**REFERENCE COMMITTEE RECOMMENDATION**—Report approved. We suggest to the membership of MAG that more physicians throughout the state offer scientific papers for publication in the *MAG Journal*. Dr. Woody's excellent management of the *Journal* is highly commended and appreciated by the Medical Association of Georgia.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the *Journal* with the additional recommendations made by the Reference Committee on motion duly made and seconded.

## Resolution No. 1

SEPARATION OF PHYSICIAN'S PROFESSIONAL FEE FROM  
HOSPITAL CHARGE

DONALD R. ROONEY, *Cobb County Medical Society*



WHEREAS, it is a long established principle of American Medicine that good patient care requires that each physician have a direct responsibility to every patient whom he undertakes to diagnose or treat, and that such a responsibility cannot be delegated to a hospital, corporation or other lay body; and,

WHEREAS, percentage contracts between radiologists or other physicians on one hand; and with hospitals, corporations or other lay bodies on the other hand are contrary to the intent of Section Six of the Code of Ethics of the American Medical Association; and to the Laws of the State of Georgia; and

WHEREAS, the Medical Association of Georgia in May, 1965 reaffirmed its policy by strongly recommending to radiologists that they revise existing contractual arrangements so that charges for radiological services be separated into a professional fee and a charge for hospital costs, and that the radiologist ordinarily should be expected to submit and collect his own bills as do other physicians; and

WHEREAS, on October 3, 1965, the American Medical Association reaffirmed its policy on Separate Billing as follows: "Hospital based medical specialists are engaged in the practice of medicine. The fees for services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be established, billed and collected by the medical specialists in the same manner as are the fees of other physicians"; and

WHEREAS, a percentage contract or any other arrangement under which a physician merges his professional fee with the hospital charges: conceals from the patient the fee of this physician, tends to identify this physician's service as a hospital service, places him in the category of a hospital employee, and furthermore constitutes a definite threat toward the ultimate inclusion of all physicians utilizing hospital facilities as hospital employees; and

WHEREAS, Public Law 89-97 makes it mandatory that no physician's professional fee be included under the hospital service component-Part A of this law, and this necessitates Separate Billing of radiologists and other physicians fees from the hospital charges with these Medicare patients; and having a different billing system for non-Medicare patients is discriminatory and would result in confusion; and

WHEREAS, Separate Billing is in operation in some Georgia hospitals now and has been in effect in hospitals in Georgia and elsewhere for several years and has proven itself to be a most satisfactory system; now therefore be it

RESOLVED, that the Medical Association of Georgia reaffirm previous American Medical Association and Medical Association of Georgia resolutions stating that fees for services of hospital based medical specialists should be established, billed and collected by these specialists in the same manner as are the fees of other physicians; and be it further

RESOLVED, that the Medical Association of Georgia define as unethical and make known its disapproval of any percentage contract or other arrangement, no matter how disguised, whereby a physician merges his professional fee with hospital charges, or allows a hospital to share in his professional fee; and be it further

RESOLVED, that the Medical Association of Georgia form a committee to dispense information and assist its

members in the implementation of these Separate Billing policies using all appropriate legal, ethical and communication channels available; and that they forward a copy of this resolution to the president and secretary of each county medical society and each hospital medical staff in Georgia, to health insurance companies in Georgia, and to the Georgia Hospital Association; and include a request that they cooperate in the implementation of Separate Billing and in abolishing percentage contracts between physicians and hospitals which in any way violate the spirit and intent of this resolution.

REFERENCE COMMITTEE RECOMMENDATION—Recommend adoption with the following editorial corrections: In the third "WHEREAS" delete the word "ordinarily" and the words "submit and," and in "WHEREAS" number four insert the word "the" in the sentence, "The fees for the services of such specialists . . .," and delete the letter "s" from the word "specialists" in the last sentence of this "WHEREAS"; and with the deletion of the words "define as unethical and" in the second "RESOLVED"; and with the deletion of the words in the third "RESOLVED," "form a committee to dispense information and"; and to insert the word "operating" in the third "RESOLVED" in order that it read "to the health insurance companies operating in Georgia."

HOUSE OF DELEGATES ACTION—Vice-Speaker Rogers recognized Donald Rooney, Marietta, for discussion. Dr. Rooney spoke in opposition to the changes in the "RESOLVED" portions of the resolution as proposed by the Reference Committee. Dr. Rooney then moved to adopt all three of the "RESOLVED" portions as they are stated in the original resolution, and this motion was duly seconded.

Fleming Jolley, Atlanta, queried about ECG in hospitals. Lester Rumble, Atlanta, spoke in support of the original resolution. M. K. Cureton, LaFayette, spoke in support of the Reference Committee's position in amending the "WHEREAS" portions and the "RESOLVED" portions as proposed by the Reference Committee.

After further discussion, the question was called, and the House approved the Reference Committee recommendations made in the "WHEREAS" portions of the original resolution and disapproved the Reference Committee recommendations made in the "RESOLVED" portions of the resolution.

By this action, the House then approved the "RESOLVED" portions as they were presented in the original resolution.

## Resolution No. 5

### DIRECT BILLING

EDWIN C. EVANS, *Fulton County Medical Society*

WHEREAS, the relationship between the physician and his patient is served best without the interposition of any third party carrier whether in the area of diagnosis and treatment or the payment for services, and

WHEREAS, it is the patient's responsibility to deal with third party carrier in matters of financial assistance with the physician being constantly aware of the principles of medical ethics, and

WHEREAS, the relationship between physician and patient is best served when there is an advance understanding regarding the payment of fees with the physician billing the patient directly for services rendered, and

WHEREAS, the AMA opposes any program of dictation, interference or coercion, whether direct or indirect, which affects the freedom of the physician to determine the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under all third-party plans;



THEREFORE BE IT RESOLVED that the Medical Association of Georgia oppose any action by any third party to interfere with the prerogative of the physician to bill his private patient directly for services rendered.

REFERENCE COMMITTEE RECOMMENDATION—Recommended adoption of Resolution No. 5.

HOUSE OF DELEGATES ACTION—The Vice-Speaker recognized Edwin Evans, Atlanta, who moved that the following sentence be added as a last sentence to the fifth paragraph of the resolution as follows: "The method of billing patients directly instead of accepting assignment is more consistent with the maintenance of the close relationship between the physician and the patient." This motion was duly seconded and approved, so that the last paragraph of Resolution No. 5, adopted by the House now reads:

"THEREFORE BE IT RESOLVED, that the Medical Association of Georgia oppose any action by any third party to interfere with the prerogative of the physician to bill his private patient directly for services rendered. The method of billing patients directly instead of accepting assignment is more consistent with the maintenance of the close relationship between the physician and the patient."

### Resolution No. 6

#### SEPARATE ANESTHESIOLOGY, PATHOLOGY AND RADIOLOGY FEES FROM HOSPITAL SERVICES

LESTER FORBES, JR., *Fulton County Medical Society*

WHEREAS, Anesthesiology, Pathology and Radiology have been repeatedly defined as an integral part of the practice of medicine, and

WHEREAS, the House of Delegates of the American Medical Association at a meeting in Chicago in October, 1965 adopted the following statement of policy:

"'Hospital based' medical specialists are included in the practice of medicine. The fees for the services of such specialists should not be merged with hospital services. The charges for the services of such specialists should be established, billed and collected by the medical specialists in the same manner as are the fees of other physicians," and

WHEREAS, the national specialty societies of these specialists have adopted similar policies for their members, and

WHEREAS, Public Law 89-97, the Medicare Law, provides for coverage of these specialists in such a manner, now,

THEREFORE BE IT RESOLVED, that these policies be approved by and become the policies of the Medical Association of Georgia, and

BE IT FURTHER RESOLVED, that all hospital laboratories be under the direction of a Pathologist, and that all independent clinical pathological laboratories be under the direction of a Pathologist or other qualified physician.

REFERENCE COMMITTEE RECOMMENDATION—Recommended adoption of Resolution No. 6.

HOUSE OF DELEGATES ACTION—The Vice-Speaker recognized Frank Miller, who spoke in opposition to Resolution No. 6, and he also recognized Lester Rumble and John Godwin, who spoke in favor of Resolution No. 6. After discussion, the House adopted Resolution No. 6: Separate Anesthesiology, Pathology and Radiology fees From Hospital Services as recommended by the Reference Committee.

### Resolution No. 8

#### INCREASE NURSES SALARIES

F. WILLIAM DOWDA, *Fulton County Medical Society*

WHEREAS, there is a general concern among physicians, hospital administrators and the general public in regard to the well publicized shortage of nursing personnel actively engaged in patient care, and

WHEREAS, there is shortage generally of paramedical personnel in our hospitals today, and

WHEREAS, this problem is a complex one involving recruitment, school operations, affiliations, financing, standards, length of training, demand for paramedical personnel in industry, public health and public schools, attrition due to marriage and lack of inducements to continue careers, and

WHEREAS, the need to improve the attractiveness of patient-care nursing careers by qualified nursing personnel is urgent, and

WHEREAS, the need to improve the attractiveness of paramedical careers generally is urgent,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia urges administrative officials and responsible governing bodies of hospitals in Georgia take effective steps without delay toward offering substantial increases in the remuneration of nurses and other paramedical personnel

AND BE IT FURTHER RESOLVED that the MAG intensify its efforts to encourage qualified personnel to enter these allied health professions by the establishment of an effective recruitment program.

REFERENCE COMMITTEE RECOMMENDATION—Recommended adoption of Resolution No. 8.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 8: Increase Nurses Salaries as recommended by the Reference Committee on motion duly made and seconded.

### Supplemental Report of Council No. G

#### BURN CENTER

CHARLES ANDREWS, M.D., *Chairman*

The following resolution was received by the Council of MAG, from the Laurens County Medical Society, at its meeting on May 7, 1966. In considering this matter the Council took note of the fact that they had previously gone on record in favor of the establishment of a "Burn Center" in Georgia. It further took note of the fact that the MAG House of Delegates had taken a similar position several years ago.

Accordingly, the Council voted to reaffirm its position on the establishment of a "Burn Center" in Georgia and further voted to refer the following resolution to the House of Delegates as a Supplemental Report of Council with the request that the House also reaffirm its position in support of the establishment of such a center.

The Laurens County Medical Society in regular session 4-25-66 passed the following resolution:

WHEREAS, in the state of Georgia, there is no place for the treatment of major burns in adults; and,

WHEREAS, there is no knowledge of the number of major burn cases in Georgia; and,

WHEREAS, there is need for research concerning the problems of burns; and,



WHEREAS, the problem of major burns is of such magnitude that very few communities or counties in Georgia can financially afford to care for these patients;

THEREFORE BE IT RESOLVED, that the Medical Association of Georgia:

(1) petition the Board of Regents and the Medical College of Georgia to organize a burn center, for the following:

1. To care for a maximum number of major burns;
2. To conduct research in the problems of burns;
3. To develop undergraduate and graduate education in the problems of burns; and to
4. Survey the state of Georgia, to learn the number of major burns, and the magnitude of the problem; and
5. Recommend to the authorities in the State of Georgia proper means of controlling this problem of burns.

**REFERENCE COMMITTEE RECOMMENDATION—**Approved in principle and recommended that Council refer to appropriate Committee for further study.

**HOUSE OF DELEGATES ACTION—**Adopted the recommendation of the Reference Committee that Supplemental Report of Council No. G: Burns Center be approved in principle and further that the MAG Council refer this Supplemental Report of Council No. G to the appropriate Association Committee for further study.

## Late Report No. 6

### TALMADGE HOSPITAL LIAISON COMMITTEE

GEORGE R. DILLINGER, *Chairman*

The Executive Committee met February 20, 1966. Attending the meeting were Drs. Charles Hock and W. A. Wilkes, representing the Richmond County Medical Society; Drs. Harry O'Rear and Rufus Payne, representing the Talmadge Memorial Hospital, and George R. Dillinger, Chairman. Dr. Henry Scoggins, President of Richmond County Medical Society, and Dr. Thomas Goodwin, Chairman of MAG Medical Education, attended at the invitation of the Chairman.

The Committee discussed certain problems regarding committee activities, and a faculty committee report was discussed. It was decided to have a meeting of the full Liaison Committee on April 16 and 17.

At the full committee meeting, in addition to the above named Executive Committee and guests, members present were Dr. Henry H. Boyter, Columbus; Dr. P. T. Scoggins, Commerce; Dr. R. W. Fowler, Marietta; Dr. Milford B. Hatcher, Macon; Dr. J. R. Turner, LaGrange; and Dr. H. G. Davis, Jr., Sylvester.

At the full committee meeting Dr. Charles Hock of Augusta gave an historical factual account that led to the establishment of the Liaison Committee. Certain matters of the relationship of the RCMS and the Medical College of Georgia were discussed which were beneficial to all concerned. The Committee decided that the Executive Committee would meet again in July or August, and the full committee in October, following the Alumni Weekend at the Medical College of Georgia.

Recommendations of the Chairman—

1. That the Committee meet as agreed in the original Talmadge Hospital Operational Policies, every six months.

2. That the Executive Committee meet each three months, when the full committee is not in session, and at the call of the chairman.

3. That the committee not only concern itself with operational policies of the hospital but also the following:

a. Public relations of the hospital and Medical College

b. Legislative problems of the hospital and Medical College

c. Aid in Continuing Education Programs of the Medical College

d. The Chairman of the Talmadge Hospital Liaison Committee be a member of the MAG Board of Medical Education

e. That members of the Liaison Committee should continue to actively serve until successors are duly appointed.

**REFERENCE COMMITTEE RECOMMENDATION--**Report approved and the Committee commended for their activities during the past year.

**HOUSE OF DELEGATES ACTION—**Adopted Late Report No. 6: Talmadge Hospital Liaison Committee as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Reference Committee No. 5 Chairman John T. Godwin, Atlanta, and duly seconded that the report of the Reference Committee be approved as amended, and it was so ordered.

Speaker Walker resumed the Chair at this time.

## Report of Reference Committee No. 6

Charles Watkins, Ellijay, *Chairman*

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)*

Reference Committee No. 6 met in Room 328, of the Ralston Motor Hotel, Columbus, Georgia, at 2:30 p.m., May 9, 1966. Members present were: Charles Watkins, Ellijay, Chairman; Robert Hubbell, Decatur, Vice Chairman; William Logan, Atlanta, Secretary; Fred Coleman, Dublin; Joseph Wilson, Atlanta; F. E. Davis, Waycross; and Menard Ihnen, Augusta.

### MAG Fee Schedule Negotiating Committee Report

HENRY S. JENNINGS, M.D., *Chairman*

The Association House of Delegates meeting May 1965 by resolution created an MAG Fee Schedule Negotiating Committee to be composed of representatives elected by their specialty or subspecialty groups (including the Georgia Academy of General Practice). This Committee was given the authority to negotiate with third parties a fee schedule subject to final approval of MAG Council.



The Committee convened its organizational meeting September 12, 1965 with physicians representing some 19 specialty or subspecialty groups. The Committee was appraised of their responsibility in the third party negotiations under the provisions of the Dependents' Medical Care Program (military medicare), the Veterans Administration Program, and other third party negotiations in behalf of the Association.

The full Committee convened again on November 20, 1965 and January 19, 1966 to consider direct negotiation on the Dependents' Medical Care Program. Because such negotiations are still in process, the Committee will make their recommendations at their next meeting which is scheduled for April 7, 1966.

So that the House of Delegates may be fully appraised of the activities of the Committee, a full report will be submitted to the House in detail as a Supplementary Report containing the final recommendations and actions of the Committee which will not be available until after the forthcoming April 7, 1966 meeting. The Committee has made interim reports of progress to MAG Council at the MAG Council meetings of September 1965, December 1965, and March 1966.

## Supplemental Report of Fee Schedule Negotiating Committee No. C

### CURRENT STATUS WITH THIRD PARTY NEGOTIATIONS

HENRY S. JENNINGS, JR., M.D., *Chairman*

Through the entire year, this Committee has had the unusually fine support, and almost 100% attendance at each meeting, of the members designated by the various Societies. Appended is a list of the members of this Committee.

Subsequent to the meeting on January 19, 1966, meetings of the Committee have been held on April 7, and April 24, 1966.

In order to accomplish the aim of negotiating fee schedules, the Committee decided to develop a "negotiating committee" relative value schedule for Georgia, and it was further decided that each organization represented would develop an RVS applicable to its own specialty—all of the RVS thus developed to be later used by the Committee if necessary.

Even more important, early in its deliberations, the Committee decided that the acceptable reimbursement of physicians by third parties would be on the basis of "usual and customary" charges. This guiding principle has subsequently dictated the course taken by the Committee in its discussions with all third parties.

As an integral part of developing and urging adoption (by third parties) of the "usual and customary" concept, certain procedures were developed and approved by the entire committee in order that a mechanism for review of physicians charges be available to third parties.

Although Military Medicare (ODMC) would have accepted a reimbursement plan based on the usual and customary concept (using their "average" fee concept), such a contract would have made MAG financially liable for payment of any amount over the "average" schedule. The Committee did not feel it had authority to possibly commit MAG financially, and accordingly, an interim plan is being developed that will result in raising the maximum allowance schedule of ODMC and for the next year allow MAG an opportunity to

obtain statistical data necessary for adoption of "average" schedule contract next year.

Discussion with Dr. Sam Blank, Veterans Administration, revealed that V.A. policies are such that negotiation prior to September, 1966, will result in a new contract for the fiscal year beginning July 1, 1968, and therefore, the present contract will, of necessity, be in effect until that date. Further meetings with representatives of the Veterans Administration will be held.

Several meetings with representatives of the John Hancock Mutual Life Insurance Company indicate an agreeable attitude on the part of their company in adopting the usual and customary charge concept with modifications of the above mentioned review mechanism for determining reasonable and prevailing fees. The Committee discouraged a statewide questionnaire survey of physician's fees, feeling instead, the presentation of claims by physicians on the basis of usual and customary charges, with an acceptable review mechanism, would result in a more valid determination of the individual physician's fees actually prevailing in Georgia. Final acceptance of this idea will undoubtedly be greatly influenced by the attitude and policies of the Social Security Administration.

### MAG HOUSE OF DELEGATES "NEGOTIATING COMMITTEE" MEMBERSHIP LIST

- (1) Georgia Heart Association  
HENRY S. JENNINGS, M.D., GAINESVILLE
- (2) Georgia Society of Internal Medicine—American College of Physicians  
EDWIN C. EVANS, M.D., ATLANTA
- (3) Georgia Pediatric Society  
H. LUTEN TEATE, M.D., ATLANTA
- (4) Georgia Society of Ophthalmology & Otolaryngology  
WILLIAM S. HAGLER, M.D., ATLANTA  
GORDON BRACKETT, M.D., ATLANTA
- (5) Georgia Association of Pathologists  
ROBERT PERRY, M.D., BRUNSWICK  
HUGH V. BELL, JR., M.D., EAST POINT
- (6) Georgia State Obstetrical & Gynecological Society  
JOHN R. MCCAIN, M.D., ATLANTA
- (7) Georgia Orthopedic Society  
ROBERT E. WELLS, M.D., ATLANTA
- (8) Georgia Chapter, American College of Surgeons  
HARRY D. PINSON, M.D., AUGUSTA  
(JOHN T. MAULDIN, M.D., Substitute)
- (9) Georgia Radiological Society  
RICHARD A. ELMER, M.D., ATLANTA
- (10) Georgia Chapter, American College of Chest Physicians  
A. GRIGG CHURCHWELL, M.D., SANDY SPRINGS
- (11) Georgia Diabetes Association  
HARVEY HAMFF, M.D., ATLANTA
- (12) Georgia Psychiatric Association  
JOSEPH SKOBBA, M.D., ATLANTA  
C. B. FULGHUM, JR., M.D., ATLANTA
- (13) Georgia Academy of General Practice  
ALBERT L. MORRIS, M.D., FAIRBURN
- (14) Georgia Chapter, American Association of Public Health Physicians  
OSCAR VINSON, M.D., DECATUR
- (15) Georgia Society of Anesthesiologists  
CLAUDE A. TAYLOR, JR., M.D., ATLANTA



- (16) Georgia Urological Association  
J. Z. McDANIEL, M.D., ALBANY
- (17) Georgia Society of Dermatologists  
HERBERT S. ALDEN, M.D., ATLANTA  
(FREDERICK E. HARDIN, M.D., Substitute)
- (18) Georgia Thoracic Society  
WILLIAM A. HOPKINS, M.D., ATLANTA
- (19) Neurosurgery  
EDGAR F. FINCHER, M.D., ATLANTA  
FLEMING JOLLEY, M.D., ATLANTA

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee approves with commendation the Fee Schedule Negotiating Committee report and the Supplemental Report No. C as submitted by the Fee Schedule Negotiating Committee. The Committee would like to note and recognize the tremendous amount of work and effort that was done by the Fee Schedule Negotiating Committee during the past year.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Fee Schedule Negotiating Committee and Supplemental Report of the Fee Schedule Negotiating Committee No. C: Current Status With Third Party Negotiations as recommended by the Reference Committee on motion duly made and seconded.

## Resolution No. 10

### DESIGNATION OF APPOINTEE TO MAG FEE NEGOTIATING COMMITTEE

CHARLES TODD, *Fulton County Medical Society*

BE IT RESOLVED that the Georgia Chapter of the American College of Surgeons be designated by the Medical Association of Georgia as the Surgical Organization in the State of Georgia which will appoint a member to the Medical Association of Georgia Fee Committee to negotiate when necessary all surgical fees in general except when specifically designated to other surgical subspecialty organizations.

**REFERENCE COMMITTEE RECOMMENDATION**—We approve Resolution No. 10 with the additional recommendation:

A committee should be continued comprised of members from the following state medical organizations: Georgia Heart Association; Georgia Society of Internal Medicine; American College of Physicians; Georgia Pediatric Society; Georgia Society of Ophthalmology and Otolaryngology; Georgia Association of Pathologists; Georgia State Obstetrical and Gynecological Society; Georgia Orthopedic Society; Georgia Chapter, American College of Surgeons; Georgia Radiological Society; Georgia Chapter, American College of Chest Physicians; Georgia Diabetes Association; Georgia Psychiatric Association; Georgia Academy of General Practice; Georgia Chapter, American Association of Public Health Physicians; Georgia Society of Anesthesiolo-

gists; Georgia Urological Association; Georgia Society of Dermatologists; Georgia Thoracic Society; Georgia Neurosurgical Society, and the Secretary of the Medical Association of Georgia.

One delegate and one alternate delegate will be designated from each of the above organizations.

The name of this Committee shall be, "The Medical Review and Negotiating Committee of the Medical Association of Georgia," and shall function as the State Medical Review Board.

We recommend a standard nomenclature of services be used.

We recommend the Committee be cognizant of changing economic standards and pursue negotiations with the carrier for proper adjustments.

**HOUSE OF DELEGATES ACTION**—Speaker Walker recognized William Dowda, Atlanta, who moved that the following sentence be inserted prior to the last sentence of the Reference Committee recommendation reading: "The Medical Association of Georgia endorses the AMA supported concept of the payment of the usual and customary fee in dealing with all parties with the realization that changing economic standards will necessitate changes in the usual and customary fee from time to time." This motion was duly seconded and approved.

Speaker Walker recognized C. J. Roper, who proposed that the Georgia Chapter, American Association of Public Health Physicians not be represented on the Medical Review and Negotiating Committee of MAG as proposed by the Reference Committee. The Chair recognized J. G. McDaniels, who spoke in opposition to the Roper motion. After the Roper motion was seconded, and duly discussed, it was adopted by the House and the action therefore deleted the Georgia Chapter, American Association of Public Health Physicians from membership on the Committee.

The House adopted the recommendations of the Reference Committee as amended above by the House.

It was moved by Reference Committee No. 6 Chairman Charles Watkins, Ellijay, and duly seconded that the report of the Reference Committee be approved as amended and it was so ordered.

Speaker Walker then called for unfinished business and there being none, Dr. Walker opened the floor for new business. There being no new business, Speaker Walker thanked each and every member of the Reference Committees for their diligent work and the entire MAG office staff and entertained a motion for the adjournment of the Second Session of the House of Delegates of the Medical Association of Georgia meeting in conjunction with the 112th Annual Session of the Association. On motion duly made and seconded, the House adjourned at 11:25 p.m.



# MAG GENERAL BUSINESS SESSION (First Session)

112th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

SUNDAY, MAY 8, 1966

THE FIRST GENERAL BUSINESS SESSION of the 112th Annual Session of the Medical Association of Georgia was called to order by President George H. Alexander, Forsyth, at 5:00 p.m., in the Municipal Auditorium, Columbus, Georgia, on May 8, 1966.

Dr. Alexander stated that the purpose of this opening General Business Session was to nominate MAG Officers, Councilors and Vice Councilors, MAG Delegates to the American Medical Association, and also to receive nominations for the MAG "General Practitioner of the Year" Award.

At this time, President Alexander appointed the MAG Tellers Committee to take charge of the official MAG Ballot Box as follows: George Dillinger, Dublin, Chairman; Fred Simonton, Chickamauga; and J. Kirk Train, Savannah. Dr. Alexander announced that the hours for balloting on the nominations made at this opening Session were as follows: May 8—5:30 p.m. to 6:30 p.m.; May 9—9:00 a.m. to 5:00 p.m., at which time the ballot box will close so that the election results may be tabulated and announced at the Tuesday morning, May 10, final Business Session.

## Nominations

President Alexander then called for nominations from the floor for the Association's Officers and the following nominations were made:

*President-Elect*—John T. Mauldin, Atlanta, nominated by Lamar Peacock, Atlanta; seconded by Charles Andrews, Canton; J. G. McDaniel, Atlanta; Thomas Anderson, Atlanta and James Kaufman, Atlanta.

Neal Yeomans, Waycross, nominated by Joseph T. Christmas, Vienna; seconded by Jack Birge, Carrollton; R. J. Moye, Swainsboro; Glenn Seymour, Albany and Robert Waller, Albany.

*Second Vice President*—M. C. Adair, Washington, nominated by Addison Simpson, Washington; seconded by Thomas Goodwin, Augusta and Charles Andrews, Canton.

There being no other nominations for the office of Second Vice President, on motion duly made and seconded, the nominations were closed and President Alexander instructed the Secretary to cast a unanimous ballot for M. C. Adair as Second Vice President of the Medical Association of Georgia.

*Secretary*—J. Rhodes Haverty, Atlanta, nominated by J. G. McDaniel, Atlanta; seconded by John Godwin, Atlanta; Preston Ellington, Augusta and W. W. Osborne, Savannah.

There being no other nominations for the office of Secretary, it was duly moved and seconded that the nominations be closed, and President Alexander in-

structed the Secretary to cast a unanimous ballot for J. Rhodes Haverty as Secretary of the Medical Association of Georgia.

## Councilors and Vice Councilors

President Alexander noted that the House of Delegates meeting in 1965 requested that effective January 1, 1966, the MAG Councilor Districts be redrawn to conform in general to the new Georgia Congressional Districts. The House also ruled that the present Council would serve until this 1966 Annual Session, at which time nominations and elections would be based on new Councilor redistricting. MAG Council, with legal advice, also ruled in the light of this redistricting, that the new 4th and 5th Districts would be synonymous with DeKalb County Medical Society and Fulton County Medical Society respectively. President Alexander then quoted from the Bylaws as follows: "Nominations for Councilor or Vice Councilor shall be made by each District Society at its Annual Meeting and forwarded by its Secretary to the Secretary of MAG not later than 15 days before the Annual Session. If no nomination is presented by a District Society, nominations shall be made from the floor. . . . Nominations from County Medical Societies are handled in like manner."

President Alexander stated that he had properly received the following nominations from the District and County Societies in advance of this meeting and that no nominations from the floor would be in order for the following offices:

*First District Councilor* (1967)—C. E. Bohler, Brooklet  
*First District Vice Councilor* (1967)—L. H. Griffin, Claxton

*Second District Councilor* (1967)—John D. Batemen, Albany

*Second District Vice Councilor* (1967)—Homer Lassiter, Arlington

*Third District Councilor* (1967)—Frank Wilson, Leslie  
*Third District Vice Councilor* (1967)—Joseph T. Christmas, Vienna

*Sixth District Councilor* (1968)—Charles T. Cowart, LaGrange

*Sixth District Vice Councilor* (1968)—J. Morgan Kellum, Thomaston

*Seventh District Vice Councilor* (unexpired term of Dr. W. C. Mitchell, 1968)—David Wells, Dalton

*Eighth District Councilor* (1968)—F. G. Eldridge, Valdosta

*Eighth District Vice Councilor* (1968)—J. W. Yeomans, Jesup

*Ninth District Councilor* (1969)—Charles Andrews, Canton

*Ninth District Vice Councilor* (1969)—Paul T. Scoggins, Commerce

*Tenth District Councilor* (1969)—Addison Simpson, Washington



*Tenth District Vice Councilor* (1969)—William Rawlings, Sandersville  
*Bibb County Medical Society Councilor* (1969)—Braswell Collins, Macon  
*Bibb County Medical Society Vice Councilor* (1969)—W. H. M. Weaver, Macon  
*Cobb County Medical Society Councilor* (1969)—W. C. Mitchell, Smyrna  
*Cobb County Medical Society Vice Councilor* (1969)—Murl Hagood, Marietta  
*DeKalb County Medical Society Councilor* (1969)—Floyd Sanders, Decatur  
*DeKalb County Medical Society Vice Councilor* (1969)—M. Freeman Simmons, Decatur  
*Fulton County Medical Society Councilor* (1967)—J. Harold Harrison, Atlanta  
*Fulton County Medical Society Vice Councilor* (1967)—Frank Wilson, Jr., Atlanta  
*Fulton County Medical Society Councilor* (1969)—Fleming Jolley, Atlanta  
*Fulton County Medical Society Vice Councilor* (1969)—Thomas Anderson, Jr., Atlanta  
*Fulton County Medical Society Vice Councilor* (unexpired term of Dr. Harrison, 1968)—Norman Berry, Atlanta  
*Richmond County Medical Society Councilor* (1969)—Harry Pinson, Augusta  
*Richmond County Medical Society Vice Councilor* (1969)—Joseph Mulherin, Augusta

## AMA Delegates and Alternate Delegates

President Alexander then called for nominations for MAG Delegates to the American Medical Association, and he stated that he would identify the elective post by announcing the name of the incumbent in office, and also giving the term of office.

*AMA Delegate* (for the office held by J. Frank Walker, Atlanta; term to run January 1, 1967 through December 31, 1968)—J. Frank Walker, Atlanta, nominated by Luther Wolff, Columbus; seconded by T. A. Peterson, Savannah; Charles Richardson, Macon and J. W. Yeomans, Jesup.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President Alexander instructed the Secretary to cast a unanimous ballot for the election of J. Frank Walker.

*AMA Alternate Delegate* (for office held by J. Kirk Train, Savannah; term to run January 1, 1967 through December 31, 1968)—J. Kirk Train, Savannah, nominated by Jules Victor, Savannah; seconded by Lawrence Lee, Savannah and W. W. Osborne, Savannah.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President Alexander instructed the Secretary to cast a unanimous ballot for the election of J. Kirk Train.

*AMA Delegate* (for office held by Henry Tift, Macon; term to run January 1, 1967 through December 31, 1967)—T. A. Sappington, Thomaston; nominated by Norman Gardner, Thomaston; seconded by Thomas Goodwin, Augusta.

John S. Atwater, Atlanta, nominated by Frank Wilson, Atlanta; seconded by Rupert Bramblett, Cumming and Harvey Hamff, Atlanta.

*AMA Alternate Delegate* (for office held by John Atwater, Atlanta; term to run January 1, 1967 through December 31, 1967)—Henry Jennings, Gainesville, nominated by P. K. Dixon, Gainesville; seconded by Edwin Evans, Atlanta.

There being no other nominations, on motion duly made and seconded, it was voted to close the nominations and President Alexander instructed the Secretary to cast a unanimous ballot for the election of Henry Jennings.

*AMA Delegate* (for office held by Preston Ellington, Augusta; term to run January 1, 1967 through December 31, 1968)—Preston Ellington, Augusta, nominated by Henry Scoggins, Atlanta; seconded by Jack Birge, Carrollton.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President Alexander instructed the Secretary to cast a unanimous ballot for the election of Preston Ellington.

*AMA Alternate Delegate* (for office held by John T. Mauldin, Atlanta; term to run January 1, 1967 through December 31, 1968)—William Dowda, Atlanta, nominated by Haywood Turner, Columbus; seconded by Charles Watkins, Ellijay and Harold Harrison, Atlanta.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President Alexander instructed the Secretary to cast a unanimous ballot for the election of William Dowda.

*AMA Alternate Delegate* (for office held by T. A. Sappington, Thomaston; the unexpired term to run January 1, 1967 through December 31, 1967)—Neal Yeomans, Waycross, nominated by J. W. Yeomans, Jesup; seconded by F. G. Eldridge, Valdosta.

At this point, Thomas Goodwin was recognized and he requested clarification on a candidate running for two elective offices. President Alexander cited Council action on the matter of a candidate running for two offices and the Chair ruled that the candidate should not offer for two posts at the same time. After further discussion, President Alexander called on the MAG Attorney, who stated that there is nothing in the Bylaws to prevent a candidate from holding two offices at the same time. After further discussion, the Chair then reversed its previous ruling, and called for other nominations for this post.

Thomas Anderson, of Atlanta, was duly nominated and seconded, but rose to withdraw as a candidate and the Chair accepted his withdrawal.

Hilt Hammett, LaGrange, nominated by Luther Wolff, Columbus, and duly seconded.

Henry Scoggins, Augusta, nominated by Julius Johnson, Augusta; seconded by William Barfield, Augusta.

## GP of the Year Award

As the last order of business of this First General Business Session, President Alexander then called for nominations for the Medical Association of Georgia "General Practitioner of the Year" Award. The following nominations were made:

Charles H. Dickens, Madison; nominated by the Oconee Valley Medical Society.

H. Homer Allen, Decatur; nominated by the DeKalb County Medical Society.



Dr. Alexander announced that these nominations were officially received, and that the House of Delegates would select from these two nominations the 1966 recipient of the "General Practitioner of the Year" Award, which would be presented at the final

Business Session, May 10.

There being no further business, the First General Business Session of the 112th Annual Session of the Medical Association of Georgia was recessed at 6:05 p.m.

## **MAG GENERAL BUSINESS SESSION (Second Session)**

### **112th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA**

### **MONDAY, MAY 9, 1966**

THE SECOND GENERAL BUSINESS SESSION of the 112th Annual Session of the Medical Association of Georgia was called to order by President George Alexander, Forsyth, at 9:00 a.m., in the Municipal Auditorium, Columbus, Georgia, on May 9, 1966.

The invocation was given by Dr. Sidney A. Gates, Pastor of the First Presbyterian Church, Columbus, Georgia.

A word of welcome was delivered by Louis A. Hazouri, President, Muscogee County Medical Society, in behalf of the membership of the Society as hosts for this 112th MAG Annual Session.

President Alexander then introduced the Honorable B. Ed Johnson, Mayor of the City of Columbus, who welcomed the membership of the Medical Association of Georgia to the city of Columbus on the occasion of the Association's Annual meeting.

President Alexander then called on President-Elect Walter Brown, of Savannah, who presented an address to the Association's membership on the Association's future activities for the year 1966-67. (This President-Elect's speech and the action pursuant to it will be found in the proceedings of the House of Delegates to which it was referred.)

President Alexander then introduced Mrs. John A. Meier, of Albany, President-Elect of the Woman's Auxiliary to the Medical Association of Georgia. Mrs. Meier, in behalf of Mrs. Louie H. Griffin, of Claxton, President of the MAG Auxiliary, presented a report on Auxiliary activities.

#### **MAG Memorial Service**

Dr. George Alexander, as Association President, then closed the Second Business Session on a solemn note with the convening of the annual MAG Memorial Service. President Alexander led the membership in repeating the 23rd Psalm in memory of those Medical Association of Georgia members deceased

during the past year. Dr. Alexander read the names of these departed colleagues as follows:

Guy H. Adams, Atlanta, April 22, 1965  
J. Mason Baird, Atlanta, April 5, 1966  
Allen H. Bunce, Atlanta, July 30, 1965  
F. Ellsworth Cale, Atlanta, March 20, 1966  
F. Phinzy Calhoun, Atlanta, May 9, 1965  
J. T. Childs, Atlanta, April 15, 1966  
M. L. B. Clarkes, Atlanta, November 8, 1965  
H. Lumpkin Coffee, Forsyth, August 8, 1965  
Allen A. Cole, Macon, November 2, 1965  
Carmen R. Cornejo, East Point, March 20, 1966  
G. K. Cornwell, Fitzgerald, August 4, 1965  
Allen W. Coward, Savannah, March 25, 1966  
Herchel C. Crawford, Atlanta, April 3, 1966  
Joseph G. Crovott, Camilla, October 21, 1965  
George R. Gish, Atlanta, May 7, 1966  
Leon Goodman, Jr., Macon, April 30, 1966  
Charles E. Hall, Jr., Atlanta, November 6, 1965  
G. T. Hendry, Blackshear, April 11, 1966  
J. H. Hodges, Atlanta, January 31, 1966  
Fred G. Hodgson, Atlanta, December 5, 1965  
P. M. Howard, College Park, November 25, 1965  
G. Pope Huguley, Atlanta, June 23, 1965  
Thomas H. Johnston, Brunswick, June 20, 1965  
William G. Keiter, Greensboro, October 29, 1965  
James H. Kelley, Newnan, March 2, 1965  
F. D. Kennedy, Baxley, December 19, 1965  
E. M. Lancaster, Shady Dale, April 2, 1965  
Thomas F. Lawless, Savannah, November 27, 1965  
R. S. Leadingham, Milwaukee, Wisconsin, February 3, 1966  
O. D. Lennard, Sandersville, November 16, 1965  
Merrill I. Lineback, East Point, December 21, 1964  
J. C. Logan, Plains, August 15, 1965  
R. H. Oppenheimer, Jacksonville, Florida, January 21, 1966  
Nicholas Overby, Sandersville, December 28, 1965  
W. H. Perkinson, Marietta, March 12, 1966  
W. P. Phillips, LaGrange, April 16, 1965  
Charles L. Prince, Savannah, July 12, 1965  
Jeff L. Richardson, Atlanta, May 9, 1965  
J. R. Robertson, Augusta, February 5, 1966  
C. A. Rhodes, Atlanta, October 10, 1965  
Allen I. Robbins, Homerville, July 24, 1965  
J. Elliott Scarborough, Atlanta, January 31, 1966  
R. S. Smith, Macon, June 28, 1965  
Lorin Van Strickland, Cobbtown, June 18, 1965  
James S. Thomas, Griffin, December 26, 1965  
W. W. Turner, Nashville, July 21, 1965  
J. P. Tye, Albany, March 25, 1965  
T. J. Vansant, Woodstock, March 31, 1966  
G. W. Willis, Ocilla, January 10, 1965  
L. E. Williams, Cordele, March 23, 1965



W. A. Williams, Sr., Macon, December 25, 1965  
L. O. Wooten, Jr., Cordele, March 23, 1965  
Jesse H. York, Atlanta, December 23, 1965  
C. R. Youmans, Hazelhurst, August 22, 1965

There being no further business, President Alexander adjourned this Second MAG General Business Session at 9:45 a.m.

# MAG GENERAL BUSINESS SESSION (Third Session)

## 112th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

### TUESDAY, MAY 10, 1966

THE THIRD GENERAL BUSINESS SESSION of the 112th Annual Session of the Medical Association of Georgia was called to order by President George Alexander, Forsyth, at 9:05 a.m., in the Municipal Auditorium, Columbus, Georgia, on May 10, 1966.

#### Fifty-Year Certificates

President Alexander called on Immediate Past President J. G. McDaniel, of Atlanta, to present the MAG Fifty-Year Certificates and Pins to physician members who have practiced medicine for 50 years or more. These presentations were made to the following physicians:

Claude A. Almand, Atlanta; Thomas J. Busey, Fayetteville; Earnest Corn, Macon; George H. Faggart, Savannah; Conway W. Hunter, Sr., Atlanta; James L. King, Sr., Macon; Samuel L. Morris, Atlanta; Lum G. Neal, Sr., Cleveland; Virgil W. Osborne, Atlanta; Albert A. Rayle, Sr., Atlanta; Robert L. Rhodes, Augusta; Relliford S. Smith, Macon; and William A. Williams, Macon.

#### Scientific Exhibits Awards

President Alexander called on John N. McClure, of Atlanta, Chairman of the Association's Scientific Exhibits Award Committee, who made the following presentations:

**First Place Award—"Prosthetic Replacement for Aortic Valve Disease"**

Robert G. Ellison, M.D.; Thomas J. Yeh, M.D.; Isam N. Anabtawi, M.D.; and V. Eugene Carnett, M.D.; Augusta, Georgia

**Second Place Award—"Injuries of the Spine: The Significance of Anatomical and Mechanical Factors"**

Robert P. Kelly, M.D., and John D. Knox, Jr., M.D., Atlanta, Georgia

**Third Place Award—"Differential Diagnosis of Certain Disorders of the Optic Disc as Seen in Three Dimensions"**

William S. Hagler, M.D.; Froncie A. Gutman, M.D.; and William H. Jarrett, II, M.D.; Atlanta, Georgia

Scientific Exhibits Chairman John McClure also presented for the first time the "Aesculapius Award" sponsored by Mead Johnson Company for excellence in scientific exhibits. This award was presented

in addition to the First Place Award to Robert G. Ellison, M.D.; Thomas J. Yeh, M.D.; Isam N. Anabtawi, M.D., and V. Eugene Carnett, M.D., of Augusta, for their exhibit titled, "Prosthetic Replacement for Aortic Valve Disease."

#### GP of the Year Award

President Alexander called on Don Schmidt, of Cedartown, President of the Georgia Academy of General Practice, to present the GP of the Year Award in behalf of MAG. Dr. Schmidt presented this high honor to Dr. H. Homer Allen, of Decatur, Georgia.

#### Election Results

President Alexander then called on the Chairman of the Tellers Committee, George Dillinger, who announced the following election results.

*President-Elect:* John T. Mauldin, Atlanta  
*Second Vice President:* M. C. Adair, Washington  
*Secretary:* J. Rhodes Havery, Atlanta  
*AMA Delegate:* (January 1, 1967-December 31, 1968)—J. Frank Walker, Atlanta  
*AMA Alternate Delegate:* (January 1, 1967-December 31, 1968)—J. Kirk Train, Savannah  
*AMA Delegate:* (January 1, 1967-December 31, 1967)—John S. Atwater, Atlanta  
*AMA Alternate Delegate:* (January 1, 1967-December 31, 1967)—Henry Jennings, Gainesville  
*AMA Delegate:* (January 1, 1967-December 31, 1968)—Preston Ellington, Augusta  
*AMA Alternate Delegate:* (January 1, 1967-December 31, 1968)—F. W. Dowda, Atlanta

Tellers Committee Chairman George Dillinger then announced that a "run off" was necessary, in that the Constitution and Bylaws of MAG called for a majority vote for election. Dr. Dillinger stated that in the three-way race between Neal Yeomans, Waycross; Hilt Hammett, LaGrange; and Henry Scoggins, Augusta, for AMA Alternate Delegate, a secret ballot between the two top candidates would be taken in a run-off election. Dr. Dillinger then instructed the Association membership to ballot between these candidates. After the ballots were



tallied, Dr. Dillinger announced the following election results:

*AMA Alternate Delegate:* (January 1, 1967-December 31, 1967)—Neal Yeomans, Waycross

### Special Presentation

At this time, President Alexander called on Mr. Fred Johnson, Branch Manager of Parke, Davis and Company, who presented the Association with four framed pictures on the history of medicine in behalf of Parke, Davis and Company. President Alexander thanked Mr. Johnson, and stated that these pictures would be hung in the MAG Headquarters Office as a fitting tribute to the proud history of the profession.

### Certificates of Appreciation

President Alexander then called on the Association's Secretary John T. Mauldin, of Atlanta, to present the MAG Certificates of Appreciation to persons recognized by the Association for their activity in behalf of the Medical Association of Georgia. Dr. Mauldin presented these certificates as follows:

George H. Alexander, M.D., as President of the Medical Association of Georgia 1965-66; John T. Mauldin, M.D., as Secretary of the Medical Association of Georgia 1960-66; Henry S. Jennings, M.D., as First Vice President of the Medical Association of Georgia; Thomas W. Goodwin, M.D., as Chairman, MAG Medical Education Board; Charles H. Richardson, M.D., as Chairman, MAG Talmadge Hospital Liaison Committee; Mrs. Louie H. Griffin, as President of the Woman's Auxiliary to the Medical Association of Georgia 1965-66; Thomas N. Lumsden, M.D., as Chairman, MAG Rural Health Subcommittee; Edgar Woody, Jr., M.D., as Editor, *Journal of the Medical Association of Georgia*; Mrs. W. Bruce Schaefer for distinguished service to the medical profession; Charles B. Watkins, M.D., for distinguished service to medicine in the Georgia General Assembly; Frank P. Holder, Jr., M.D., for distinguished service to medicine in the Georgia General Assembly; Carl P. Savage, Sr., M.D., for distinguished service to medicine in the Georgia General Assembly; A. Sidney Johnson, Sr., M.D., for distinguished service to medicine in the Georgia General Assembly; J. Lee Walker, M.D., for service to the medical profession; Harry B. O'Rear, M.D., for service in the field of medical education; Arthur P. Richardson, M.D., for service in the field of medical education; Charles S. Jones, M.D., as Councilor, Fifth District and Fulton County Medical Society 1956-1966; Virgil B. Williams, M.D., as Fourth District Councilor 1958-1966; Honorable Peter Zack Geer, Lieutenant Governor, State of Georgia, for service to the medical profession; Henry H. Tift, M.D., as Delegate to the AMA, 1959-1966; M. A. Hubert, M.D., as Tenth District Vice Councilor, 1960-1966; W. Frank McKemie, M.D., as Second District Councilor, 1962-1966; and J. C. Brim, M.D., as Second District Vice Councilor, 1962-1966.

### Humanitarian Service Award

President Alexander then presented a certificate of Humanitarian Service for Dr. John H. Ridley, of Atlanta, which was accepted by Dr. Edgar Woody in behalf of Dr. Ridley. This award was presented by the American Medical Association in recognition of the meritorious service Dr. Ridley performed for the medical profession, the United States Government, and the people of South Viet Nam by treating

the ill and injured during his voluntary medical mission in South Viet Nam.

### MAG Hardman Award

President Alexander called on President-Elect Walter Brown to make the presentation of the Association's Hardman Award. This award is given for the achievement of anyone, who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery or such contribution to the science of medicine.

President-Elect Walter Brown then made this presentation to Dr. Perry P. Volpito, of Augusta.

### Site of 1968 Annual Session

President Alexander announced that the site for the 1967 Annual Session had been previously set for Atlanta, Georgia, on the invitation of the Fulton County Medical Society. Dr. Alexander then called for invitations to MAG to convene the 1968 Annual Session.

Jules Victor, Jr., of Savannah, President of the Georgia Medical Society was recognized and rendered an invitation to the Association to hold its 1968 Annual Session in Savannah, Georgia, and the invitation was referred to MAG Council with an expression of appreciation to the Georgia Medical Society for their invitation.

### Official Attendance Record

President Alexander announced that the official attendance at the 112th Annual Session of the Medical Association of Georgia held in Columbus, Georgia, May 8-10, 1966, was as follows:

MAG Members—510, Other Physicians—38; Guests—95; and Exhibitors—126; thereby making a grand total of 769 registered.

### Installation of Officers

The next order of business was the installation of 1966-67 Officers and Councilors and Delegates as follows:

*President*—Walter Brown, Savannah (1967)  
*President-Elect*—John T. Mauldin, Atlanta (1967)  
*Immediate Past President*—George Alexander, Forsyth (1967)  
*First Vice President*—Lamar Peacock, Atlanta (1967)  
*Second Vice President*—M. C. Adair, Washington (1967)  
*First District Councilor*—C. E. Bohler, Brooklet (1967)  
*First District Vice Councilor*—L. H. Griffin (1967)  
*Second District Councilor*—John D. Bateman (1967)  
*Second District Vice Councilor*—Homer L. Lassiter (1967)  
*Third District Councilor*—Frank A. Wilson (1967)  
*Third District Vice Councilor*—Joseph T. Christmas (1967)  
*Sixth District Councilor*—Charles T. Cowart (1968)  
*Sixth District Vice Councilor*—J. Morgan Kellum (1968)  
*Seventh District Vice Councilor*—David A. Wells (1968)  
*Eighth District Councilor*—F. G. Eldridge (1968)  
*Eighth District Vice Councilor*—J. W. Yeomans (1968)



*Ninth District Councilor*—Charles R. Andrews, Jr. (1969)  
*Ninth District Vice Councilor*—P. T. Scoggins (1969)  
*Tenth District Councilor*—Addison W. Simpson (1969)  
*Tenth District Vice Councilor*—William Rawlings (1969)  
*Bibb County Medical Society Councilor*—Braswell E. Collins (1969)  
*Bibb County Medical Society Vice Councilor*—W. H. M. Weaver (1969)  
*Cobb County Medical Society Councilor*—W. C. Mitchell (1969)  
*Cobb County Medical Society Vice Councilor*—Murl M. Hagood (1969)  
*DeKalb County Medical Society Councilor*—Floyd R. Sanders (1969)  
*DeKalb County Medical Society Vice Councilor*—M. Freeman Simmons (1969)  
*Fulton County Medical Society Councilor*—J. Harold Harrison (1967)  
*Fulton County Medical Society Vice Councilor*—Frank L. Wilson, Jr. (1967)  
*Fulton County Medical Society Councilor*—Fleming L. Jolley (1969)  
*Fulton County Medical Society Vice Councilor*—Thomas J. Anderson, Jr. (1969)  
*Fulton County Medical Society Vice Councilor*—J. Norman Berry (1968)  
*Richmond County Medical Society Councilor*—Harry D. Pinson (1969)

*Richmond County Medical Society Vice Councilor*—Joseph L. Mulherin (1969)  
*AMA Delegate*—J. Frank Walker (Jan. 1, 1967-Dec. 31, 1968)  
*AMA Alternate Delegate*—J. Kirk Train (Jan. 1, 1967-Dec. 31, 1968)  
*AMA Delegate*—John S. Atwater (Jan. 1, 1967-Dec. 31, 1967)  
*AMA Alternate Delegate*—Henry Jennings (Jan. 1, 1967-Dec. 31, 1967)  
*AMA Delegate*—Preston Ellington (Jan. 1, 1967-Dec. 31, 1968)  
*AMA Alternate Delegate*—F. William Dowda (Jan. 1, 1967-Dec. 31, 1968)  
*AMA Alternate Delegate*—Neal Yeomans (Jan. 1, 1967-Dec. 31, 1967)

Outgoing President Alexander then turned over the gavel of leadership to incoming President Walter Brown, who expressed his appreciation to the membership for their cooperation and interest, and there being no further business, President Brown adjourned the 112th Annual Business Session of the Association at 12:45 p.m.

## NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Bivens, Edward S. Active—Fulton	Sewell & Fairburn Road, S.W. Atlanta, Georgia 30331	Rutledge, Ben A. Active—Fulton	1365 Clifton Road, N.E. Atlanta, Georgia 30333
Celaya, Carlos L. Active—Fulton	401 Peachtree Street, N.E. Atlanta, Georgia 30308	Santos-Buch, Charles A. Active—Fulton	717 Woodruff Building Atlanta, Georgia 30322
Christy, James H. Active—Fulton	1365 Clifton Road, N.E. Atlanta, Georgia 30333	Stone, William D. Active—Fulton	25 Third Street, N.W. Atlanta, Georgia 30318
Crymes, James E. Active—Fulton	Box 171, 80 Butler St., S.E. Atlanta, Georgia 30303	Tauber, Charles P. Active—Fulton	415 E. Paces Ferry Road, N.E. Atlanta, Georgia 30305
Del Cueto, Jose R. Active—Fulton	2391 Sewell Road, S.W. Atlanta, Georgia 30311	Wildstein, Gilbert Active—Fulton	340 Boulevard, N.E. Atlanta, Georgia 30312
Farrar, W. Edmund, Jr. Associate—Fulton	69 Butler St., S.E. Atlanta, Georgia 30303		
Klopstock, William J. Service—Fulton	441 W. Peachtree Street, N.E. Atlanta, Georgia 30308		
Lyon, James B. DE-2—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303		
Mayo, Edwin A. Active—Glynn	3010 Hampton Avenue Brunswick, Georgia 31502		
McKenzie, Donald J. Active—Thomas-Brooks	818 Gordon Avenue Thomasville, Georgia 31792		
McKinney, Alexander S. Active—Fulton	1365 Clifton Road, N.E. Atlanta, Georgia 30333		
McPheeters, Harold L. Active—Fulton	130 Sixth Street, N.W. Atlanta, Georgia 30313		
Peters, Margaret P. Active—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303		
Piper, Robert S. Active—Richmond	2161 Telfair Street Augusta, Georgia 30904		
Ramsay, Allan B. Active—Richmond	2123 McDowell Street Augusta, Georgia 30904		
Roberts, Don R., Jr. Active—Glynn	3010 Hampton Avenue Brunswick, Georgia 31520		

### "MD" CAR BUMPER STICKERS AVAILABLE TO GEORGIA DOCTORS

The green and white, reflective "MD" stickers, which a physician may attach to his car bumper, are once again available from the Medical Association of Georgia.

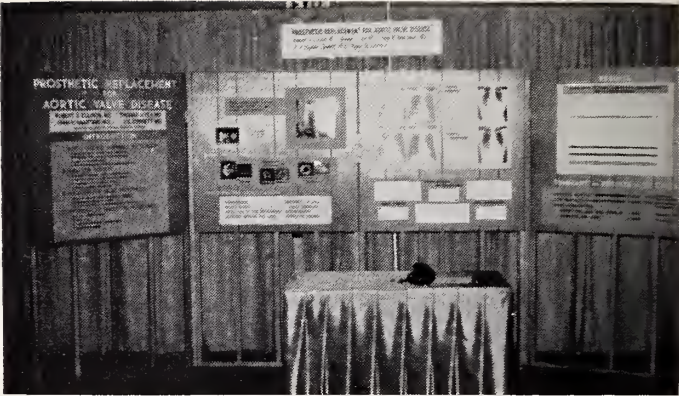
Complete with the seal of the Medical Association and the admonition to "Drive Safely," the stickers may be obtained, free of charge, by writing to: *Medical Association of Georgia, 938 Peachtree St., N.E., Atlanta, Ga. 30309.*







1966-67 President-Elect, John T. Mauldin, M.D., of Atlanta.



First Place Scientific Exhibits Award, "Prosthetic Replacement for Aortic Valve Disease," Robert G. Ellison, M.D.; Thomas J. Yeh, M.D.; Isam N. Anabtawi, M.D., and V. Eugene Carnett, M.D., Augusta, Georgia.

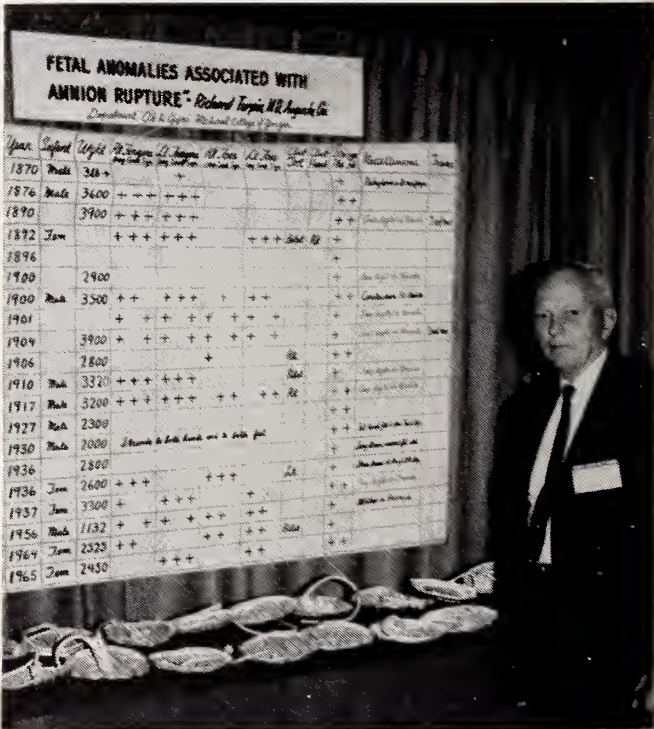


Henry Homer Allen, II, M.D. of Decatur (left), MAG "General Practitioner of the Year," receives his award and congratulations from GAGP President, Don Schmidt, M.D. of Cedartown.

# 112th Annual Session Columbus



MAG Ballot Box receives a vote from W. Frank McKemie, M.D., of Albany (left), while Woman's Auxiliary member, and Past President, George R. Dillinger, M.D. of Dublin look on.



Prominent Augusta physician, Richard Torpin, M.D., is shown with his scientific exhibit.





Mrs. Bruce Schaefer, Atlanta, Director of Family and Children's Services, is pictured with John Venable, M.D. (left), Director of the Georgia Department of Public Health, and (right) Mr. Lawrence B. Gilman, Vice-President, John Hancock Mutual Life Insurance Co., Boston, Mass. Standing left to right—Henry S. Jennings, M.D., Gainesville; Mr. John H. Moye, Executive Director, Blue Cross of Columbus, and Mr. Douglass Richard, Regional Representative, Bureau of Health Insurance, Social Security Administration, Atlanta.



Immediate Past President, George H. Alexander, M.D. of Forsyth (left), receives a Certificate of Appreciation from newly elected President-Elect and former MAG Secretary, John T. Mauldin, M.D., of Atlanta (right).



Georgia Lt. Governor, Peter Zack Geer, is greeted by MAG member.

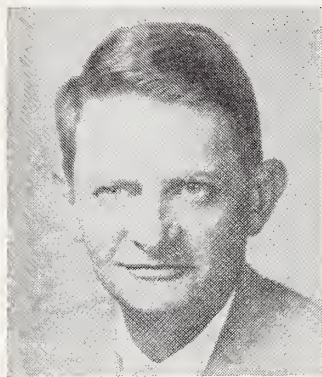
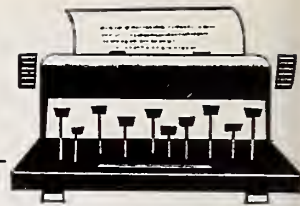


Irving D. Hellenga, M.D. of Toccoa dictates to MAG Secretary, Nancy Minor.



Reference Committee in action hears F. William Dowda, M.D., of Atlanta.





## Atlantan, John T. Mauldin, Elected 1966-67 MAG President-Elect

**J**OHN TYLER MAULDIN, Atlanta surgeon, and two-term former Secretary of the Medical Association of Georgia, was elected to serve as MAG President-Elect for 1966-67 at the recent meeting of the Association held in Columbus, May 8-10, 1966. Dr. Mauldin first became Secretary of MAG in 1960 at the Association's 106th Annual Session in Columbus. He succeeded Dr. Christopher J. McLoughlin, also of Atlanta.

A native of Thomaston, Dr. Mauldin attended Riverside Military Academy at Gainesville. He received his undergraduate training at Emory University and his medical degree from Emory University School of Medicine. He served his internship at Grady Memorial Hospital, Atlanta, and his residency at the Steiner Cancer Clinic, Grady Memorial Hospital, and the Lawson VA Hospital.

During World War II, Dr. Mauldin attained the rank of major, serving as Battalion and Regimental Surgeon. He is a retired colonel in the Georgia Air National Guard, having served as Wing Surgeon.

Dr. Mauldin is a member of the hospital staffs of Emory University Hospital, Grady Memorial Hospital, Crawford W. Long Hospital, Georgia Baptist Hospital and St. Joseph's Infirmary. He is a member of the Board of Directors and Professional Education Committee of the Georgia Division, American Cancer Society; Medical Director, Adult Recipient Program, Welfare Department; a member of the MAG Committee on Hospital Relations; and a member of the Georgia Hospital-Medical Council. He is a fellow of the American College of Surgeons, a member of the American Board of Surgery, a member of the Southeastern Surgical Congress, and is Chairman of the Governor's Commission on Aging.

The new President-Elect is a member of Kappa Sigma social fraternity, Theta Kappa Psi medical fraternity and North Avenue Presbyterian Church.

Dr. and Mrs. Mauldin, the former Ann Scott Harman, have four children and live at 2804 Andrews Drive, N.W.

## Renal Transplantation

**S**LIGHTLY MORE than a decade ago the transplantation of a kidney from a living donor to a recipient suffering from chronic renal disease was accomplished at the Peter Bent Brigham Hospital. The kidney survived, functioned normally and completely

relieved the uremic syndrome in the recipient, thus proving the technical feasibility and functional integrity of such a graft. The fact that the donor and recipient were identical twins obviated the host-versus-graft reaction in this initial experiment. Since then



more than 30 such isografts have been done. In addition, over 400 renal homografts, utilizing related donors, unrelated living donors, and cadaver kidneys, have been attempted, with varying degrees of success. Since the main problem in homografts is the rejection phenomenon, the selection of a donor from close relatives, as might be expected, has led to greater success than using unrelated donors.

### Continued Improvement

Continued improvement in the success of renal homografts depends upon progress in several fields. Technical proficiency, of course, improves with experience and may be expected to progress as surgeons gain more experience in this field. The problem of rejection has been attacked by the use of radiation and immunosuppressive drugs to reduce the capacity of the recipient to react to the transplanted tissue. Radiation has now largely been replaced by drugs, usually a combination of Imuran and cortico-steroids, with fewer side effects and fatal infections.

The approach offering the most hope for further improvement in results is in the field of histocompatibility testing. This science, at present in its infancy, must eventually make it possible to identify tissue antigens much as major blood groups are currently identified. This would then make possible the selec-

tion of donor organs on a rational basis to modify the rejection process. Combined with "tissue banks" where organs could be stored in a viable state, this would solve many of the existing problems in donor selection and availability.

### Still Experimental

Meantime, current experience is good enough to warrant continued optimism in this field. Certainly not every patient with chronic renal failure is a candidate for renal transplantation, nor should every medical center feel the obligation to "bridge the gap" in venturing into this field, which still must be considered experimental. Many ethical and moral problems exist in the selection of donors and the surgical removal of a kidney from a healthy person. The use of cadaver kidneys, currently not as satisfactory, may one day be the principal source of supply when improved selection and storage methods are available.

The advances of the past decade in renal transplantation are indeed impressive, and are a credit to those who have pioneered in this field. It has brought closer the day when the patient with chronic renal failure may look to the future with hope.

*Joseph S. Wilson, M.D.  
490 Peachtree Street, N.E.  
Atlanta, Georgia 30309*

## DISPENSING THE SAMPLE

The samples you get from drug companies are intended for one purpose: to be given to patients as a trial. However, if no written prescription accompanies the sample, the transaction looks like the dispensing of a home remedy; or looks as if the patient is being used as a guinea pig. Common sense suggests that the sample should be accompanied by a written prescription for the same item.

### Tell the Patient

It might be best to tell the patient: "This is a sample of a new (or a good old) medicine that has had some fine results. If it is as favorable as I expect it to be, take the prescription to your neighborhood drug store so you can get more of this medicine. If you are disappointed in the results, call me."

This simple procedure will prevent the embarrassment of an otherwise satisfied patient trying to get the drug without a prescription. It will lift the medication into the dignified "prescription" class rather than make it look like a casual free sample. It indicates that the doctor is not going out on a limb, calling it a wonder drug. And it acts as an automatic (if not entirely scientific) check on the effectiveness and safety of a new drug.

## 1966 CALENDAR OF MEETINGS

### State

July 15-16—Twentieth Annual Rocky Mountain Cancer Conference, Brown Palace Hotel, Denver, Colo.

September 26-27—Tennessee Valley Medical Assembly, Trivoli Theater, Chattanooga, Tenn.

April 30-May 1-2, 1967—113th Annual Session of the Medical Association of Georgia, Marriott Motor Hotel, Atlanta.

### Regional

June 30-July 2—Symposium on Clinical Aspects of Renal Disease-Ischemic Heart Disease and Cardiac Diagnosis (Sponsored by Tidewater Heart Association, Council on Clinical Cardiology, American Heart Association), Cavalier Hotel, Virginia Beach, Va.

August 14-19—The Southeastern School of Alcohol Studies, The University of Georgia Center for Continuing Education, Athens.

August 24-26—Thirteenth Western Cardiac Conference, "Ischemic Heart Disease," University of Colorado Medical Center, Denver, Colo.

September 8-10—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.

### National

June 26-30—American Medical Association Annual Convention, Chicago.

August 12-13—National Conference on Infant Mortality sponsored by the American Medical Association's Committee on Maternal and Child Care, Fairmont Hotel, San Francisco.

*The Journal of the Medical Society of New Jersey, 62: December, 1965.*





## PRESIDENT'S LETTER

### THE YEAR AHEAD

AS I WRITE this letter, we are still looking forward to a most fruitful and enriching annual meeting of the Medical Association of Georgia at Columbus. Everyone there has gone all out to make it successful from both a scientific and social standpoint.

#### To Foresee With Clarity

We are approaching rapidly the time for activation of the Medicare law and all its ramifications. None of us can at this time foresee with clarity the many problems which its advent will present to us as physicians, to our hospital and nursing home facilities, and to additional problems of operating our private offices. We are again being told that the program is to be rapidly expanded.

There will be an entire day just prior to the opening of the AMA meeting in Chicago in June for a new and up-to-date review and study of present regulations, and a look into the future as to what we will most likely anticipate as next steps and directions which this expansion may take.

#### Delegation in Washington

On May 26 we will have a joint meeting of our legislative committee and our congressional delegation in Washington. This will be preceded by an outline from our AMA office in Washington concerning proposed and likely legislation in which we are vitally interested. Our congressmen and senators will be invited to give their views about such legislation and, in time, will be given our position on these.

The American Medical Association meeting in Chicago in June will be of tremendous importance, and for those who have not attended, we urge as many of our members to do so as possible. For those

who attend regularly, it is always to be looked forward to.

All members are urged to visit the Southeastern Hospitality Room, co-sponsored by the Southern states, also, to assist the delegates and alternates at reference committee meetings and other activities of our delegation.

#### Meeting With Governor Sanders

We have recently held our Executive Committee joint meeting with Governor Sanders. This was to discuss problems pertaining to recent developments at the Milledgeville Hospital. The Governor requested our cooperation in obtaining a qualified medical director. Also, it was decided that it is very necessary to obtain a full-time hospital business administrator to relieve the medical director of these duties. It was agreed that decentralization of patients at Milledgeville should be accomplished as rapidly as feasible—this to be accomplished by activating new facilities.

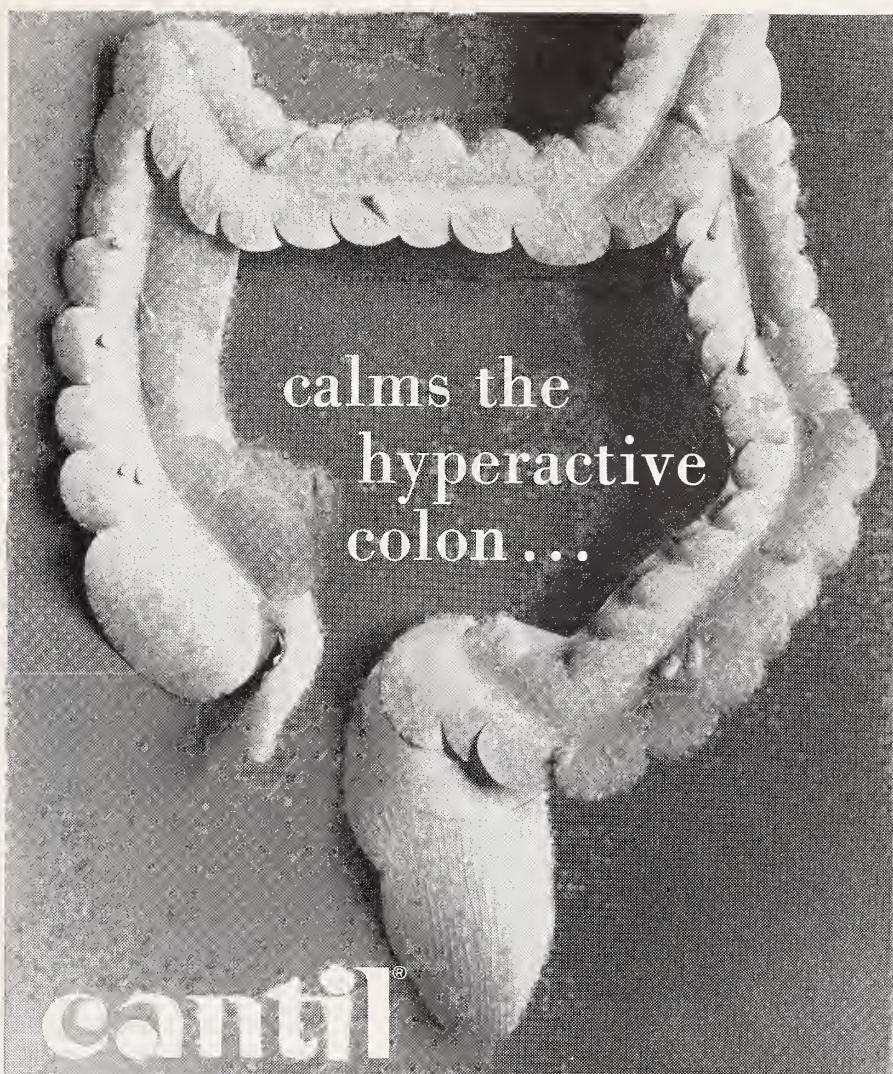
The Governor also requested further cooperation and conferences after release of the Bowdoin report. We are happy to continue our pleasant and fruitful contacts with the Health Department, and to aid in all areas to improve the care of our mentally ill.

I have a great task in stepping into the role vacated by George Alexander. He has done a tremendous job during the past year. With the help and advice of all our officers and members, I will do my best.

Walter E. Brown, M.D.

President, Medical Association of Georgia





(mepenzolate bromide)

## *helps restore normal motility and tone*

**Cantil** (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."<sup>1</sup>

### **IN BRIEF:**

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957



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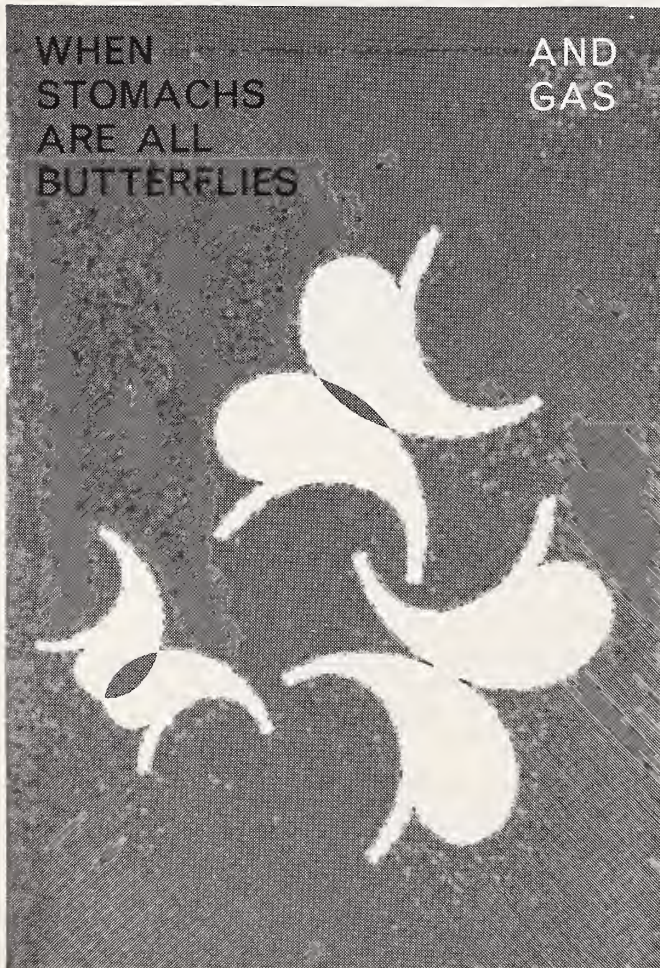
## DACTILASE®

Each tablet contains:

Dactil® (piperidolate hydrochloride), 50 mg.;  
Standardized cellulolytic\* enzyme, 2 mg.;  
Standardized amylolytic enzyme, 15 mg.;  
Standardized proteolytic enzyme, 10 mg.;  
Pancreatin 3X\*\* (source of lipolytic activity),  
100 mg.; Taurocholic acid, 15 mg.

\*Need in human nutrition not established.

\*\*As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

### Side Effects and Contraindications:

Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

**Administration and Dosage:** One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

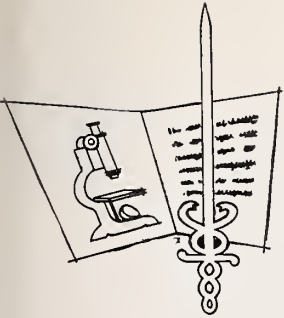
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EVERY DAY





### CARE OF THE COLON RECTUM CANCER PATIENT

Henry Finch, M.D., *Atlanta*

**W**HEN THE PATIENT comes to the doctor's office for a physical examination, the finding and care of early cancer is only half begun. The physical examination is only half done when a complete inspection and palpation from head to toe is completed. The patients now know and generally insist that a pap smear and a chest film be made. The neglected part of the examination is most often the rectal examination.

#### To Be Adequate

The rectal examination must include the sigmoidoscopic exam if it is to be adequate. Digital examination is only fair for eight or nine centimeters. In these cases only large lesions are felt. The pedunculated polyp and soft villous adenoma are missed. At the Strong Clinic, with digital examination of the rectum, only 9.5% of cases of rectum and colon could be diagnosed, but with the sigmoidoscopic examination, 76.5% could be diagnosed.<sup>1</sup>

If blood is in stool taken from sigmoidoscope or if polyp is found, a barium enema should also be done.

In our resolve to take care of patients, we should be sure to include a sigmoidoscopic exam. Cancer

of the rectum and colon, when asymptomatic, produces about an 80% five-year cure rate. If it is symptomatic, this is only about 30%.<sup>2</sup>

#### Growing Interest

To demonstrate to the physicians in Georgia the various techniques used in proctoscopic examination, a program was co-sponsored by the Department of Surgery, Emory University; the Southeastern Surgical Congress and the American Cancer Society, Georgia Division, on March 3, 1966, at the Grady Memorial Hospital Auditorium. Interest in this course was much greater than had been predicted. Over 100 physicians attended, showing the growing interest in this program.

#### REFERENCES

1. Hertz, R. E. L.; Deddish, M. R., and Day, E.: Value of Periodic Examinations in Detecting Cancer of the Rectum and Colon; *Postgrad. Med.* 27:290-294.
2. Shadon, D. B., and Wangenstein, O. H.: Early Diagnosis of Cancer of the Gastrointestinal Tract; *Postgrad. Med.* 27:306-311.

490 Peachtree Street, N.E.

*Approved by the Professional Education Committee, Georgia Division, ACS.*

### QUERIES ON NEW MEDICARE LAW ARE ANSWERED

*Excerpts from questions posed by physicians in attendance at the MAG County Medical Society Leadership Conference, February 5, 1966, as answered by representatives of the Social Security Administration on the new "Medicare" law, P.L. 89-97.*

#### (5) Determining "reasonable charges."

Where payment by the program is on the basis of charges (for physicians' services and medical and other health services not furnished by providers of services), the carriers are to take action to assure that the charge on which the reimbursement is based is reasonable and not higher than the charge used for reimbursement on

behalf of the carriers' own policyholders or subscribers for comparable services and under comparable circumstances.

In determining reasonable charges, the carriers will have to consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services.

The use by carriers of certain existing mechanisms and procedures will help in the determination of whether a charge is reasonable. For example, procedures established by State or local medical societies for resolving fee questions are regularly utilized by carriers.



For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.

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FOR COLD  
HANDS AND FEET**



## GERILID™

Each chewable tablet contains:  
nicotinic acid (niacin) 75 mg. and  
aminoacetic acid (glycine) 750 mg.

**Administration and Dosage:** One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

**Side effects:** Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

**Supplied:** Packages of 50 chewable tablets.

Also available in liquid form as Geriliquid®, in bottles of 8 and 16 ounces.

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## THE MARTYR

J. Kenneth McDonald, M.D., *Augusta*

EVERY PHYSICIAN who has contact with patients will be familiar with "the Martyr." This individual's story is one of stoic suffering, not only of physical pains but other "slings and arrows of outrageous fortune." They can go on and on, with a little encouragement, telling of the abuse that has been heaped upon them. Family and friends have long taken advantage of them, but the patient has never been able to defend himself for one reason or another. The martyr had much rather "just take it than hurt someone's feelings." In short, a lifelong pattern of making themselves feel useful and worthwhile by doing for others is well established. Of course, the more suffering one does in the process of doing, the more worthwhile one can feel. This need to feel strong through suffering results many times in the development of multiple somatic complaints.

These patients are difficult to treat. If the physician abruptly questions the martyr's somatic symptoms or style of life, then he is immediately like everyone else; not understanding, mean and cruel, and therefore, just one more cross for the martyr to bear. On the other hand, if the physician does not attempt to intervene, then the pattern will continue and grow, and much time and money will be spent in needless diagnostic procedures and therapeutic attempts.

These patients seem particularly prone to having undergone surgical procedures.

Treatment has to be oriented around acceptance of the patient as a person first, and also around attempts to get the patient to understand his habitual approach to relating to others. This will necessitate a discussion of daily living and what goes on between the patient and Aunt Sally, their in-laws, members of their church, etc. When the relationship with the patient is well established and one has accumulated enough concrete evidence of how the patient is making life hard for himself, then the physician can attempt to discuss these habitual patterns of living directly with the patient.

Don't be too surprised, however, if after the above has been done, the patient says, "Doctor, you're right, and I'm going to try real hard to do what you want me to do so that you can make me well. I know it is going to be hard for me to do all of these things you're asking me to do with people, but I'll sure try to do them for you. By the way, what am I going to do now about this gas on my stomach and these backaches?"

*1445 Harper Street*

*Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.*

## QUERIES ON NEW MEDICARE LAW ARE ANSWERED

*Excerpts from questions posed by physicians in attendance at the MAG County Medical Society Leadership Conference, February 5, 1966, as answered by representatives of the Social Security Administration on the new "Medicare" law, P.L. 89-97.*

(3) *Can a physician "participate" with some patients and choose to bill other patients as usual?*

We assume "participate" means to accept assignment by the patient for direct payment from the carrier. If so, the answer is yes. It is entirely the physician's choice whether to accept assignment or to bill the patient in the regular way.

As stated above, if the physician accepts assignment for direct payment from a carrier for an unpaid bill, the physician must agree that the amount determined by the carrier as a reasonable charge for the service rendered will be considered the full amount of the bill.

If the physician bills the patient, the amount of the bill and the method of payment to the physician will concern only the physician and the patient. In cases such as this, the carrier will reimburse the patient for the reasonable charge of the service on the basis of a receipted bill.





## THE CARDIAC RESUSCITATION TRAY

Samuel O. Poole, M.D.  
*Gainesville*

SINCE 1960 when Kouwenhoven first reported successful closed-chest cardiac massage, there has been an ever-increasing interest in cardiac resuscitation. This has paid great dividends, and over the past few years as more and more people have learned this technique, many lives have been saved that would otherwise have been lost. The technique of closed-chest massage should be a part of every hospital training program and should be taught to all hospital personnel. It is the feeling of many that this technique should also be taught to lay rescue groups (firemen, policemen, etc.) and where practiced has at times been shown to be very effective.

### Necessary Items

The purpose of this article is to discuss the other things needed in conjunction with cardiac resuscitation. The first step in cardiac arrest is always the beginning of external cardiac compression and the maintenance of an airway and respiratory activity. After this has been done, one has time to collect his thoughts, get electrocardiographic proof of the basic rhythm mechanism and decide what else is needed. In certain acute emergency situations one often needs a variety of different drugs and equipment in a short period of time. It is very helpful to have assembled such necessary items as a cardiac resuscitation tray ready to go at a moment's notice.

The items listed on the following page are considered to be necessary in the make-up of any resuscitation tray. This is a rather lengthy list, but it does give the physician what he needs to handle

most emergency situations. This is best assembled on a cart with two or three shelves, constructed of heavy gauge steel with a low center of gravity to prevent tipping. The check-list noted is used currently at the Hall County Hospital. It is the responsibility of specified individuals to check this cart daily to make sure all items are present. It is a great temptation for nursing personnel to remove drugs and other items of equipment from the cart when needed for other non-emergency purposes. Because of this, the cart should be checked daily for readiness.

### Available Carts

At the present time there are several commercial crash carts available which contain a DC defibrillator, external pacemaker, positive pressure breathing apparatus and closed heart massage equipment. These are quite elaborate and desirable if one can afford them. They are quite expensive and since most hospitals have already invested in separate pieces of resuscitative equipment they are not willing to purchase such a cart. The crash cart is not essential for good results. If one has a good understanding of the problems and physiology of cardiac arrest, a satisfactory defibrillator, a means of maintaining an airway and respiratory activity, and a great deal of perseverance, he can do a good job with these patients. Good results do not depend on fancy and expensive equipment.

1114 Vine Street

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*Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.*



## CHECK-LIST FOR EMERGENCY RESUSCITATION TRAY

Week of \_\_\_\_\_

Unit \_\_\_\_\_

	M	T	W	T	F	S	S
1. Sterile knife handle							
2. Sterile blades							
3. Syringes							
a. 2 cc (6)							
b. 6 cc (2)							
c. 12 cc (4)							
d. 20 cc (2)							
e. 50 cc (1)							
f. Insulin syringe							
4. Needles:							
a. Cardiac (2)							
b. #18 gauge							
c. #21 gauge (5)							
d. #23 gauge (5)							
e. Blood airways							
5. Airway (resusitube)							
6. Tourniquet (4)							
7. Alcohol sponges in containers							
8. Tongue blades (4)							
9. Applicators (4)							
10. I.V. Set (2)							
11. #35 Endotracheal tube							
12. Laryngoscope							
13. Tracheotomy tray							
14. Levine tube							
15. Suction Machine							
16. O <sub>2</sub> gauge, catheter, mask							
17. Cut-down--emergency tray							
18. Suction tubing							
19. 4x4 Towels--sterile							
20. Jelly							
21. Drugs:							
a. Aminophyllin gr. 7½ "IV" (3)							
b. Aminophyllin gr. 3-3/4 "IV" (3)							
c. Isuprel "IV" (5)							
d. Aramine "IM" or "IV" (2 vials)							
e. Wyamine "IM" or "IV" (1 vial)							
f. Pronestyl "IM" or "IV" (2 vials)							
g. Adrenalin 1:1000 (5 amp)							
h. Aq. Mephyton (5 amp)							
i. Atropine gr. 1/150 (12 tablets)							
j. Ephredrine 0:05 gm. (5)							
k. Prostigmine							
l. Caffeine & Na Benzoate (4)							
m. Levophed (4)							
n. Coramine (5)							
o. Digoxin 0.5 mgm. (4)							
p. Cedilanid (3)							
q. Ca. Gluconate (3)							
r. Glucagon (1 amp)							
s. Glucose 50% 50 cc amp. (3)							
t. Quinidine gluconate (2)							
u. Mag. So <sub>4</sub> (2)							
v. Nitroglycerin gr. 1/200 (12 tab.)							
w. Solu Cortef 100 mgm (2)							
x. Na Bicarb 3.75 gm (4)							
y. Molar Lactate (4)							
z. Neosynephrine (5)							
a. Novacaine 1 & 2% (2 each)							
b. Calcium Chloride (3)							
c. Sod. Iodide (3)							
d. Dilantin (1)							
e. Premarin (1)							
f. KCL 40 meq and 20 meq (1 each)							
g. Mannitol (1)							
22. Blood Set and Blood Pump (1)							
23. 1000 cc DS-W (1)							
24. 1000 cc DS-S (1)							
25. 1000 cc N.S.							
26. Dextran 500 cc (2)							

Checked by (initials)



ONE PINT  
OF BLOOD  
PROVIDES  
NO MORE  
IRON

THAN ONE 5 CC.  
AMPUL OF



Obstetrical or post—surgical patients requiring a dependable increase in hemoglobin will receive as much iron (250 mg. in a 5 cc. ampul) as in one pint of blood. Imferon (iron dextran injection) is less expensive and it avoids the well-recognized hazards of whole blood transfusion. When patients cannot—or cannot be relied upon to—take oral iron, Imferon (iron dextran injection) will rapidly supply needed iron for reserve stores.

## IMFERON® (iron dextran injection)

**IN BRIEF: ACTION AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

**COMPOSITION:** Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

**ADMINISTRATION AND DOSAGE:** Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

**SIDE EFFECTS:** Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

**PRECAUTIONS:** If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

**CONTRAINDICATIONS:** Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

**CARCINOGENICITY POTENTIAL:** Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

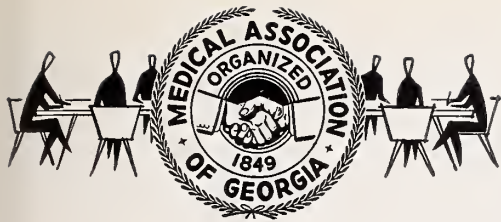
**SUPPLIED:** 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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# THE ASSOCIATION

## DEATHS

**J. R. Childs**, Atlanta physician for 52 years, died April 15, 1966.

Dr. Childs, an ear, nose and throat specialist, graduated in 1914 from the Atlanta Medical College. He did postgraduate work at Johns Hopkins University, Baltimore.

He was on the staff of several Atlanta hospitals and was a longtime member of the board of trustees of Piedmont Hospital.

He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association and the Southern College of Physicians and Surgeons.

Dr. Childs was past director of the Druid Hills Golf Club.

He was a member of the Baptist Church.

Surviving are sons, John R. Childs, Santa Maria, Calif., James B. Childs, William H. Childs and Charles T. Childs, all of Atlanta; and sister, Mrs. C. R. (Aurelia) Brown, Atlanta.

**Herschel C. Crawford**, Atlanta physician for 35 years, died April 3, 1966, in a private hospital.

A native of Toccoa, Dr. Crawford graduated from the Emory University Medical School in 1919 and did postgraduate work in Vienna, Austria, and New York City.

He was past staff president of Georgia Baptist and Piedmont hospitals. He also had served on the staffs of Crawford W. Long, St. Joseph's and Henrietta Eggleston hospitals.

Dr. Crawford was past president of the Fulton County Medical Society and the Medical Association of Georgia. He had been a member of the board of trustees of Piedmont Hospital since 1932 and a member of the board of directors of Blue Cross. He was also past president of Blue Shield.

At his death, Dr. Crawford was assistant professor of ophthalmology at Emory University.

He was a member of the Second-Ponce de Leon Baptist Church, the Capital City Club, Piedmont Driving Club, the Masons and the Shrine.

Survivors other than his wife include a son, James L. Kelly, Atlanta; two brothers, John M. Crawford, Toccoa, and Dr. Hugh Crawford, Daytona Beach, Fla., and two sisters, Mrs. R. R. McKnight, Toccoa, and Mrs. William R. King, Sr., Griffin.

**George Tracy Hendry**, 86, of Blackshear died April 11, 1966, at Pierce County Hospital following a short illness. He was a graduate of the Atlanta School of Medicine, now Emory University and was married to the former Emma Armitage who died in 1948. He was a member of the First Methodist Church of Blackshear, the Blackshear Masonic Lodge, the Ware County Med-

ical Society, the Medical Association of Georgia and the American Medical Association. At one time he served on the Pierce County Board of Education.

Survivors include two sons, Dr. William A. Hendry of Blackshear and Dr. E. Dudley Hendry of Waycross, and seven grandchildren.

**T. J. Van Sant, Sr.**, 89-year-old Woodstock physician, died in Shoreham Rest Home March 31, 1966.

Dr. Van Sant had practiced medicine in Woodstock for more than 50 years. He had worked his way through school by taking on jobs that included teaching, selling and splitting rails. He graduated from the old Georgia College of Eclectic Medicine and Surgery in Atlanta in 1907.

The Medical Association of Georgia had honored Dr. Van Sant with a recognition pin for 50 years of service, an open house was held in his honor in Woodstock when he celebrated his golden anniversary as a practicing physician in 1962.

Survivors include his wife, Mrs. Birdie Lovinggood Van Sant; daughter, Mrs. H. L. Skeen, Ballwin, Mo.; sons, W. A. Van Sant, Jasper, Dr. T. J. Van Sant, Jr., Marietta; 12 grandchildren; one great-granddaughter; sisters, Mrs. Vertie Erwin, Winter Haven, Fla., Mrs. Jessie Milner, Gadsden, Ala.; brother, Dr. J. P. Van Sant, Dewey, Okla.; and several nieces and nephews.

**Louis Oswell Wootten, Jr.**, 60, Cordele physician and surgeon, died March 23, 1966, at Emory University Hospital.

Dr. Wootten attended Mercer University, Macon, where he received his premedical training and was a graduate of the University of Georgia Medical School. He served his internship at Duval County Hospital at Jacksonville, Fla., and did postgraduate work at the Lying-In Hospital of New York.

During World War II, Dr. Wootten served in the U. S. Army at Jefferson Barracks, in St. Louis, Mo.

Dr. Wootten was a member of the Flint Medical Society, Medical Association of Georgia and the American Medical Association. He was a member of the Baptist church, a former member and past president of the Cordele Lions Club, and served as a member of the Cordele Board of Education.

Survivors are his wife, the former Miss Kathryn Royal of Cordele; one son, Jimmy Wootten of Cordele; a daughter, Miss Kathy Wootten of Cordele; and one sister, Miss Aurelia Wootten of Cordele.

**J. Mason Baird**, a former Columbus resident and physician, died April 5, 1966, in an Atlanta hospital.

Dr. Baird was a member of the American Medical Association, the Emory University Hospital staff and other medical organizations.

Survivors include his widow, Mrs. Katrena Sharp Baird, and a brother, Emmett Holt Baird, both of Atlanta.



## THE ASSOCIATION / Continued

### COUNTY MEDICAL SOCIETIES

New officers of the **Seventh District Medical Society** were elected at the April meeting held in Rome. Harry Dawson, M.D. of Shannon was elected President; Clarence Sapp, M.D., Rome, was named President-elect; and Murphy K. Cureton, M.D. of LaFayette was elected Secretary-Treasurer.

The spring meeting of the **Third District Medical Society** was held at Americus April 14, 1966. Three Columbus doctors gave talks on different subjects in the medical field. Dr. Frank Starr spoke on "Carcinoid Tumors"; Dr. Philip Schley discussed "Clinical Applications in Renal Arteriography"; and "Plastic Surgery, Interesting Cases" was the subject of the talk by Dr. John Van Duyn. In the business session, the group adhered to the new political districting of the state and re-elected two delegates to the state body to fill their own unexpired terms. Dr. Frank Wilson, Americus, is counselor and Dr. J. T. Christmas, Vienna, is vice-counselor.

### PERSONALS

#### First District

**Elton S. Osborne, Jr.**, a native of Savannah, has been appointed Deputy Director of the Georgia Department of Public Health.

#### Third District

**Jack C. Hughston** of Columbus has been appointed a member of the Committee on Medical Aspects of Sports of the American Medical Association.

**A. Eugene Lee** will leave his medical practice in Buena Vista in June to return to the University of Mississippi for additional study in the field of law. **John Rogers**, now a resident physician at the Medical Center, Columbus, will take over Dr. Lee's medical equipment and facilities at the Buena Vista Clinic.

**Dan Callahan**, Warner Robins, is one of eight physicians who have volunteered for duty as part of Project Viet-Nam. The volunteers left May 3, 1966. Dr. Callahan is a general practitioner in private practice in Warner Robins.

#### Fifth District

**Dorothy Jaeger-Lee**, an Atlanta pediatrician, has recently given up her practice to become a pediatric psy-

chiatrist. Dr. Jaeger-Lee is now a first-year resident in psychiatry at Emory University School of Medicine and is spending the first phase of her training at the Georgia Mental Health Institute, Atlanta.

**Robert E. Wells**, Atlanta, spoke on, "What's in It for Me?" at the Eighth Annual meeting of the Allied Medical Careers Club of Georgia held at Rock Eagle in Eatonton, April 15-17, 1966.

Two professors at Emory University School of Medicine have edited a new medical textbook on the heart.

**J. Willis Hurst**, Chairman of Emory's Department of Medicine and Chief of Medicine at Grady Memorial Hospital, and **R. Bruce Logue**, Chief of Medicine, Emory University Hospital, are the authors.

The 1,255-page book, entitled *The Heart, Arteries, and Veins*, is a product of five years of work.

As a representative of the Georgia Heart Association, **Robert I. Lowenberg**, Atlanta, talked to the Farm Bureau of Rockmart recently on developments in the Cardiovascular Surgery Field.

#### Sixth District

**Corbett Thigpen**, Chief of Psychiatry at University Hospital, Augusta, spoke in March at Mercer University in the final of several forums sponsored by *The Macon Telegraph and News*.

**John W. Kemble**, at present Professor of Neurology at the Medical College of Georgia, will join the medical staff at Milledgeville State Hospital July 1 as Director of the Department of Neurology.

#### Seventh District

The American Academy of General Practice has announced that **Richard C. Manus**, Austell, has been accepted for membership in the Georgia chapter of AAGP.

#### Tenth District

**Everett Kuglar**, Chief of In-patient services at Talmadge Memorial Hospital, Augusta, was the featured speaker at an area Mental Health Association meeting in North Augusta, S. C., April 1, 1966. Dr. Kuglar's topic was, "Mental Health's Greatest Need."

**Carol Graham Pryor**, Augusta physician, spoke to members of the Sylvania Woman's Club at their regular meeting April 12, 1966. "Education—An Antidote to Poverty," was the topic of Dr. Pryor's speech.

### QUERIES ON NEW MEDICARE LAW ARE ANSWERED

*Excerpts from questions posed by physicians in attendance at the MAG County Medical Society Leadership Conference, February 5, 1966, as answered by representatives of the Social Security Administration on the new "Medicare" law, P.L. 89-97.*

(2) *What is the difference between an "intermediary" and a "carrier"?*

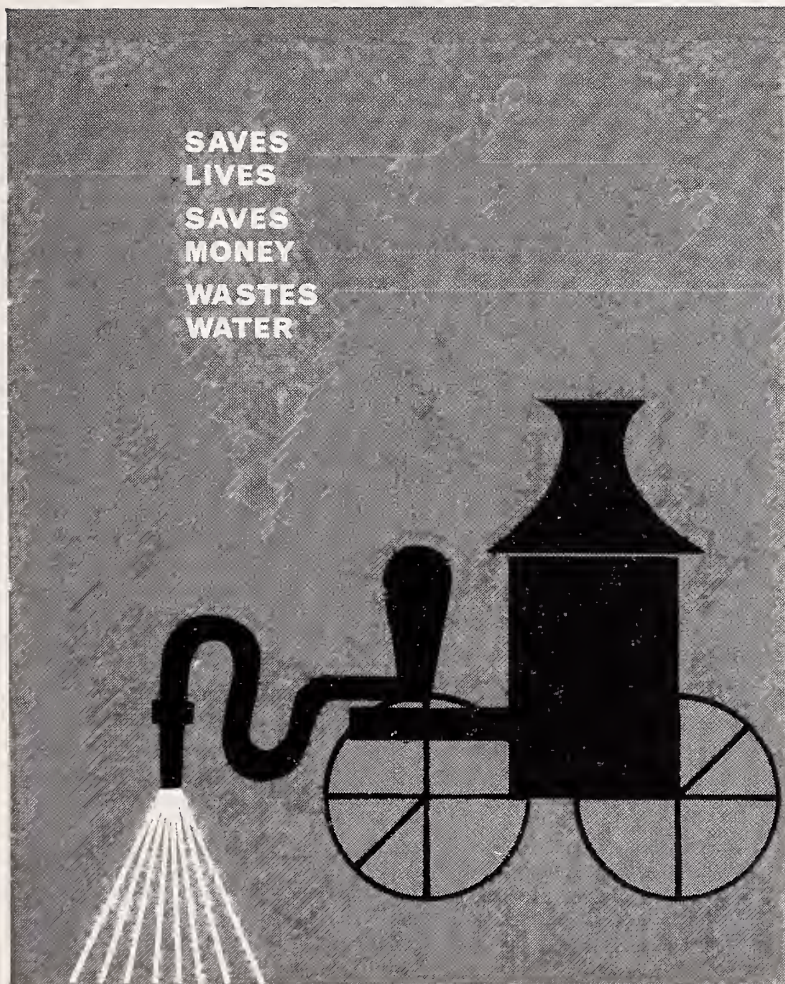
Basically, an intermediary is a private or public organization or agency which serves as the Government's contracted agent to make payments for reasonable costs

of inpatient hospital (and other provider) services and certain outpatient, laboratory and home health services. In short, the intermediary will reimburse for expenses covered by the hospital insurance part of the program (Part A).

A carrier is referred to in the law as a private insurance company, group health plan or voluntary medical insurance plan having experience in reimbursing physicians. Carriers will make payments for the reasonable charges of physician's services and other medical services under Part B.



SAVES  
LIVES  
SAVES  
MONEY  
WASTES  
WATER



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**Dosage:** One 2 or 4 mg. tablet once or twice daily.

**Precautions:** As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

**Side Effects:** Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

**Contraindications:** Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

**How Supplied:** Bottles of 100 and 1000 tablets.

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AND  
KEEP IT DOWN**

190  
102

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Each scored tablet contains:  
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2 mg. or 4 mg. and  
Reserpine 0.1 mg.

**Usual adult dose:** One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

**Contraindications:** Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

**Supplied:** Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

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**NORPRAMIN<sup>®</sup>**  
 (desipramine hydrochloride)  
 non-sedating • rapid-acting  
**ANTIDEPRESSANT**

**overcomes guilt, lifts depression, restores confidence**

Feelings of guilt, worthlessness, emptiness and loss frequently characterize depression. Such feelings, along with insomnia, physical complaints, sadness, apprehension, and other symptoms of depression rapidly respond to Norpramin (desipramine hydrochloride). Improvement often begins in 2-5 days, sometimes in less. A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

**Indications:** In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Side effects, usually mild may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

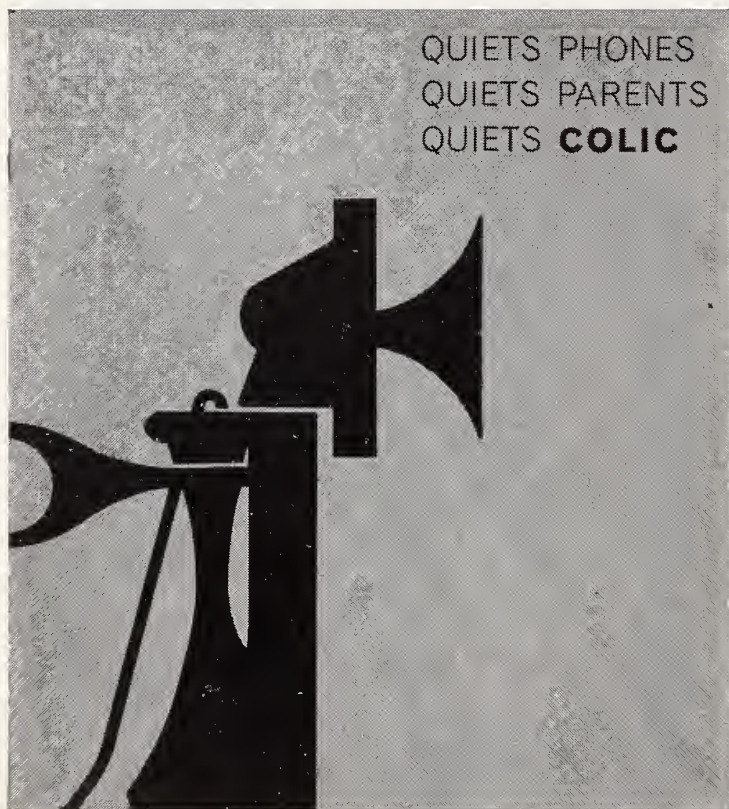
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In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.



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each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT  
(For all information)

Form Approved.  
Budget Bureau No. 72-R7341

JOURNAL  
THE MEDICAL  
SOCIATION

JULY 1966  
Georgia

From  
HEALTH  
INSURANCE

NAME OF BENEFICIARY (Patient)

CLAIM NUMBER

☐ MALE ☐ FEMALE

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

Describe the illness or injury for which you received treatment. (You do not need to complete this item if your doctor completes Part II below)

Was your illness or injury connected  
with your employment?

☐ YES ☐ NO

3. Are you attaching itemized  
received bills?

☐ YES ☐ NO

ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier?

☐ YES ☐ NO

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.

REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

SIGNATURE (Patient or authorized representative)

DATE SIGNED

ADDRESS (Street address, City, State, ZIP Code)

TELEPHONE NUMBER

PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, Including Physician's Signature,  
Need Not Be Completed If Paid, Itemized  
Bills Are Submitted.

A. DATE OF EACH SERVICE	B. PLACE OF SERVICE	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (Diagnosis)	E. CHARGES	Leave Blank
				\$	

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NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number and street, City,  
State, ZIP Code)

TELEPHONE NUMBER

CODE NO.

9. Total  
Charges

\$

10. Amount  
Paid

\$

11. Any Unpaid  
Balance Due

\$

ASSIGNMENT OF PATIENT'S BILL  
(See reverse)

☐ I ACCEPT ASSIGNMENT

☐ I DO NOT ACCEPT ASSIGNMENT

SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's  
services were personally rendered by him or under his personal direction)

☐ MD ☐ DO ☐ DDS  
OR  
DMD

DATE SIGNED

Doctor's Office

IH—Inpatient Hospital

ECF—Extended Care Facility

OL—Other Locations (Specify in 7C)

Independent Laboratory (give name and address in 7C)

H—Patient's Home

OH—Outpatient Hospital

NH—Nursing Home



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# LOWER EXTREMITY AMPUTATIONS AT GRADY MEMORIAL HOSPITAL

John N. McClure, Jr., M.D.; Stewart H. Shippey, M.D.;  
Peter H. Stokley, M.D., and J. D. Martin, Jr., M.D., *Atlanta*

## ■ A Ten Year Study from 1952 through 1961

FROM TIME TO TIME it is appropriate to statistically analyze the results obtained in the treatment of any given pathological entity. Such a study should include a description of the patients involved, the method of treatment, and a review of the mortality, morbidity and complications which might be influenced by improvements or advancements in surgical therapy. This analysis is such a study. For purposes of comparison, the results of amputation surgery obtained in other institutions have been reported by several authors.<sup>1-8</sup> It should be kept in mind that patients having toe and transmetatarsal amputations were included in some of the above reports and their results are therefore not entirely comparable to the present series.

### Ten-Year Period

All patients undergoing lower extremity amputation, above or below the knee, at Grady Memorial Hospital during the ten-year period—1952 through 1961, were studied. The hospital serves the indigent population of the metropolitan area of Atlanta and many of the patients exhibited severe malnutrition and debilitation on admission. Gangrene and infection were frequently in advanced stages due to neglect or fear of going to the hospital. An attempt was made to prepare all patients for surgery and place them in as good preoperative status as possible. Such preparation included the administration of blood or fluids and the regulation of diabetes and cardiac decompensation. Antibiotics were given to those with infections. Some patients had toe amputations or drainage procedures prior to above or below knee

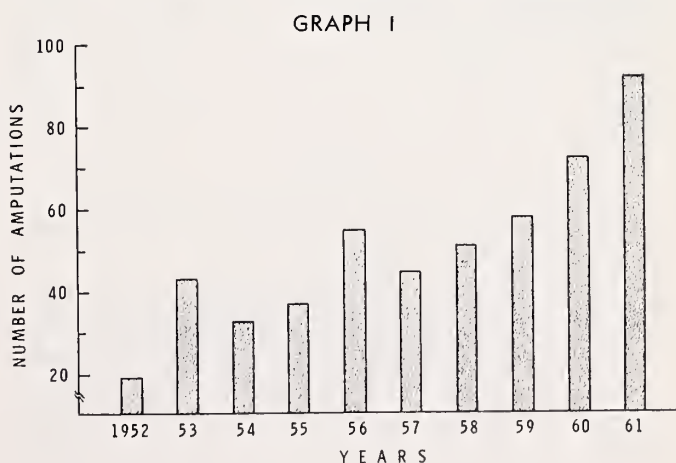
amputation, but were included in this study only if amputation about the knee was done. Most procedures were done under either spinal or general anesthesia; rare cases were done under local anesthesia.

### Operative Technique

The operative procedures were done by members of the resident staff with the supervision of the attending staff. The standard techniques for below the knee or above knee amputation were usually employed. It is not appropriate to go into the technical details since there were so many operators involved, and minor variations would naturally occur from surgeon to surgeon. Most of the wounds were closed primarily with drainage. However, in badly infected cases, wounds were left open and skin traction was usually applied. In these, secondary closure was performed in one or two weeks depending upon the status of the wound and the general condition of the patient.

During the study period, 457 patients underwent 505 primary amputations about the knee.

Graph 1 shows the increasing frequency of this



Presented at the 112th Annual Session of the Medical Association of Georgia, May 8, 1966, Columbus, Georgia.

From the Department of Surgery, Emory University School of Medicine, Grady Memorial Hospital.



**AMPUTATIONS / McClure et al**

TABLE I  
 RACE AND SEX

Patients	Number	Percent
Male .....	255	56
Female .....	202	44
White .....	187	41
Negro .....	270	59
Total .....	457	100

GRAPH 2

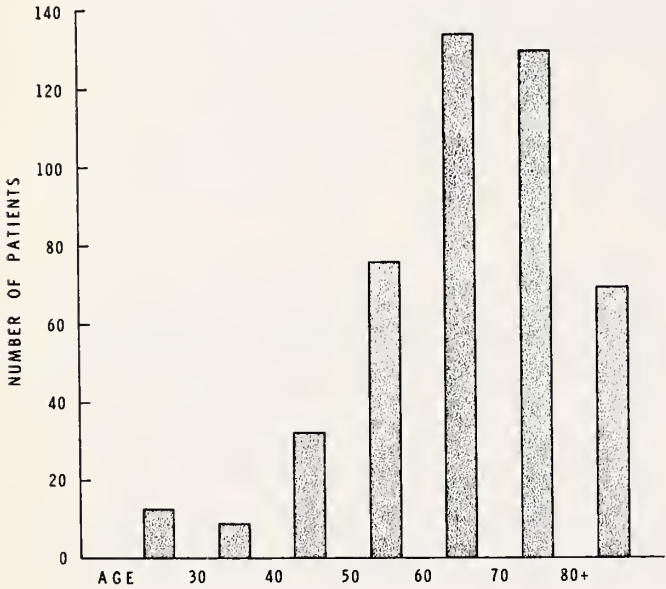


TABLE II  
 DIABETES AND INFECTION

Nondiabetic patients .....	297—65%
Diabetics .....	160—35%
Infection present in foot or extremity preoperatively .....	293—64%

TABLE III  
 DISEASES CAUSING AMPUTATION AMONG NONDIABETICS

	Number	Percent
Arteriosclerosis .....	258	87
Trauma—(Acute 19, Chronic 16) .....	35	11.8
Emboli .....	25	8.4
Other vascular disease .....	23	7.7
Tumor .....	7	2.3
Paraplegia .....	4	1.3

TABLE IV  
 CONCOMITANT DISEASES

	Heart	CNS	Lung	Renal	Obesity	Cancer	Other
Number .....	285	86	74	33	24	8	68
Percent .....	62	19	16	7	5	2	15

procedure at Grady Hospital. Among 505 amputations done, 69 were below the knee, and 436 were above the knee, a ratio of one to six. Among these done below the knee 15 (22%) subsequently required revision above the knee. By the end of the study period, 110 patients (24%) had been encountered who lost both legs. Many times these patients had the first amputation elsewhere and came to Grady hospital for the second. This fact accounts for the apparent disparity in the number of amputations done in the patient group.

In *Table I* patients are divided into race and sex, and it can be seen that there were 11% more males than females and that there were 18% more Negroes than whites.

*Graph 2* demonstrates the age of the patient by decade, and the fact that 331 or 72.5% were over age 60. About equal numbers of patients are in the fifth and eighth decades, and the sixth and seventh decades. The relatively few patients requiring amputation below age 50 were mostly victims of trauma, paraplegia or tumor, and collectively they constituted only 15.4% of the entire series.

*Table II* reveals that 35% of the patients were diabetics, and that 64% had preoperative infections of the toes, foot or leg. The latter category was often difficult to determine from the charts examined. In general, patients who had “dry” gangrene were regarded as noninfected, and those having “wet” gangrene were regarded as infected. However, some of the patients in the dry group had a moderate amount of local infection at the gangrenous toes and were therefore included in the infected group. This classification is by no means exact and would vary considerably among surgeons in private practice or other institutions.

In *Table III* the non-diabetic group was subdivided further into various reasons for amputation. As expected, arteriosclerosis was responsible for the largest number of cases, these far outnumbering all other causes combined. In this table the “other” vascular diseases included Buerger’s disease, phlegmasia cerula dolens, periarteritis nodosa, etc.

The high incidence of concomitant disease is shown in *Table IV*. This is another factor which is significantly related to total mortality and morbidity in the series, but in a disproportional manner. From this table one might expect to find heart disease as the primary cause of death among all patients; however, as subsequently shown in *Table VIII*, it is sepsis which heads this list.

*Table V* indicates the incidence of common post-operative complications. By far the greatest problem is wound infection which occurred in 117 patients, 26% of the entire series, and 60% of the complications. This high incidence is no doubt re-



lated to the equally high (64%, Table II) rate of preoperative infection in the extremities.

Wound infection often made the regulation of diabetes difficult and therefore contributed to the prolonged hospital stay of many patients, as shown in Table VI. Sixty-one percent of the patients were discharged from the hospital prior to the twentieth day, and 39% remained in the hospital longer than 20 days. Approximately one-fourth (23%) stayed in the hospital longer than a month, and approximately ten percent remained two months or longer.

Table VII shows the age by decade of patients dying in the hospital following amputation. As expected, the greatest mortality occurs in those over 60, but the rate in those younger is still quite appreciable and probably reflects the severity of the underlying pathological process necessitating this operative procedure. It was also found that 105 patients (23%) died within 30 days of surgery. Some of these patients had been sent home and expired there.

Primary Cause of Death

The primary cause of hospital deaths as outlined in Table VIII was sepsis; with stroke, pulmonary embolus and heart failure falling closely behind. The "other" causes of hospital deaths were numerous and sometimes combined and difficult to establish. Many of the patients had concomitant cardiac failure, strokes, liver failure, diabetes and sepsis along with pneumonia and kidney disease. A few patients expired in shock immediately after operation.

Table IX shows the number of patients who had prior amputation of the opposite or simultaneous amputations of both extremities. Those having amputation on one side, followed later by the removal of the remaining extremity, constituted 24% of the entire series. The patients having prior below the knee amputation requiring above the knee revision numbered only 15. This figure indicates a relatively good selection of patients for this operative procedure, as a certain number of failures naturally would be expected. Simultaneous amputation of both extremities was done mainly in paraplegic patients and patients with acute trauma.

Lumbar sympathectomy was performed on 15% of the patients prior to amputation, days, weeks, or months preoperatively. The value of this operation in delaying the onset of gangrene is questionable.

Revascularization procedures, grafts or endarterectomies were done in so few patients as to be statistically insignificant. Results obtained following these operations will be reported subsequently.

Summary

Patients requiring major lower extremity amputation in our population continue to come primarily

TABLE V  
POSTOPERATIVE COMPLICATIONS

	Wound Infection	Hematoma	Lung	Heart	Pulmonary Emboli	Diabetic	Other
Number	117	11	16	8	7	8	13
Percent	60	6	8.8	4.4	4	4.4	7
Total complications							182—40%
Wound infection of entire series							117—26%

TABLE VI  
LENGTH OF STAY IN HOSPITAL

Days	1-4	5-9	10-19	20-29	30-59	60
Number	10	110	158	76	59	44
		278		179	103	
Percent		61		39	23	10

TABLE VII  
HOSPITAL DEATHS BY AGE

	1-49	50-59	60-69	70-79	80	Total
Number	7	12	20	23	21	83
			64			
Percent	8.5	14.5	77			100
83 Deaths = 18% of Total Patients						

TABLE VIII  
PRIMARY CAUSE OF HOSPITAL DEATHS

	Number	Percent
Sepsis	22	27
Stroke	11	13
Pulmonary embolus	11	13
Heart failure	9	11
Other—combined	30	36
Total	83	18% of total series

TABLE IX  
PRIOR AND SIMULTANEOUS AMPUTATIONS

	Number	Percent
Prior amputation of opposite extremity	110	24
Prior BK amputation on same side requiring AK revision	15	22
Simultaneous amputation of both extremities		
Above knee	8	
Below knee	1	



from the older age groups. In addition to gangrene and infection of the foot or extremity, most of these patients have concomitant diseases in one or more systems. These factors contribute to a relatively high morbidity and mortality rate. The incidence of post-operative wound infections, and the frequency of sepsis as a cause of death would indicate that infections are a major problem even when antibiotics are liberally used to combat them.

The frequency of pulmonary embolus as a cause of death theoretically could be lowered by vein ligation or anticoagulant therapy. Past experience with the former has shown it to be ineffective; and with the latter, as many problems are created as solved.

As a general principle it is recommended that all patients with pre or minimally gangrenous toes be studied by arteriograms. The correction of arterial obstructions should be the preferred method of lowering the total amputation rate and its attendant complications.

## **FIRST NATIONAL CONGRESS ON MEDICAL ETHICS HELD AT CHICAGO**

State and County Medical Society representatives met in Chicago March 5-6, 1966, to attend the American Medical Association's First National Congress on Medical Ethics. This outstanding program included such topics of discussion as "Professional Ethics in a Time of Change," "Medicine—A Profession or a Business?," "Economics and Ethics," and "Medical Etiquette."

### **Panel Workshop**

The highlight of the program was audience participation in small panel workshops where discussion centered on subjects such as "Grievance Committees," "Appeals to State Professional Conduct Committees and AMA Judicial Council," "Medicine and the Law," and "Discipline by State Boards of Medical Examiners." Dr. Walter H. Judd of the AMA Judicial Council presented a stirring address on ethics titled, "Can the Best Be Better?" Participants in the Congress were given an "Ethical I.Q. Test" based on hypothetical cases involving medical ethics.

During the Congress, medicine's relationships with optometry, podiatry, and osteopathy were discussed in detail. The Congress closed on a positive note with a presentation on medical ethics titled "Be a Physician First."

The Medical Association of Georgia President, Chairman of the Ethics Committee, Chairman of the Public Service Board and Chairman of the Medical Education Board represented MAG at this Congress. These representatives stated that the Association should consider presenting a similar meeting on medical ethics for Georgia physicians, at some future date, so that this reexamination and rededication to medical ethics could be brought to the local level.

However, with any modality of therapy, the results obtained in a group of aged patients exhibiting advanced vascular disease, multiple organ involvement, malnutrition and debility will be frequently discouraging.

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## **AMERICAN MEDICAL ASSOCIATION TO SPONSOR EIGHTH NATIONAL CONFERENCE ON THE MEDICAL ASPECTS OF SPORTS**

The Eighth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Las Vegas, Nevada, at Caesar's Palace on November 27, 1966. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

As was true of the previous seven Conferences, the Eighth will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums and discussion sections relating to criteria for immediate management of knee injuries, resources for grass roots supervision of sports, medical preparations for international competitions, and the relationship of athletic fitness to physical fitness. Among the speakers will be Merritt Stiles, M.D., 2d Vice President of the U. S. Olympic Committee, and Donald O'Donoghue, M.D., President of the American Academy of Orthopedic Surgeons. Robert S. Rocke, M.D., Medical Examiner for the California State Athletic Commission, will address the Conference Luncheon.

The Conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the Conference should address the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.



# CONTRIBUTIONS TO THE PATHOLOGICAL ANATOMY OF HIATAL HERNIA

John A. Androulakis, M.D.  
John E. Skandalakis, M.D.  
Stephen W. Gray, Ph.D., *Atlanta*

- Suggestions are made for materially reducing the ten percent recurrence rate following surgical repair.

**I**N THE ESOPHAGEAL hiatus of the diaphragm, the surgeon often fails to find the structures described by the anatomist. This is because the anatomist describes the normal hiatus in the young, while the surgeon sees chiefly the incompetent hiatus of middle age.

The purpose of this paper is to emphasize certain surgico-anatomical points which the authors have observed during the dissection of cadavers with hiatal hernia.

Ten fresh cadavers of individuals with clinical, radiological and anatomical evidence of sliding hiatal hernia were dissected. All were males about 40 years of age. Six were muscular and well-nourished, the other four were asthenic.

## Results

### *The Phreno-esophageal Membrane*

The phreno-esophageal membrane has usually been described in infants or in young muscular individuals (Botha 1958). It is composed largely of elastic fibers which arise from the subpleural and subperitoneal connective tissue of the diaphragm and insert in the connective tissue of the esophagus above the diaphragm (Hayward 1961). It may have a component which inserts into the gastric cardia (Botha 1958).

With age the membrane becomes less definite, and the esophagus is less firmly fixed in the hiatus. Adipose tissue appears between the surviving elastic fibers. By middle age, when hiatal hernia may occur, the membrane has almost lost its identity. For all practical purposes, it does not exist in patients with hiatal hernia.

### *The Hiatal Ring*

There is wide variation in the relative participation of the right and left crura in the formation of the hiatal ring. Eleven variations have been described by Listerud (1964). There is no reason to believe that one arrangement of crural fibers predisposes to hiatal hernia more than another (Listerud and Harkins 1959).

In all of our specimens both crura participated in the formation of the hiatal ring. In five cases a median arcuate ligament was present connecting the two crura anteriorly to the aorta. In five other specimens, no trace of such a structure was found. The medial tendinous crural fibers continued upward to the hiatal margin without forming a median ligament.

The normal anatomy of the hiatus was altered in all of our specimens, and for practical purposes the opening was surrounded by a fleshy ring composed of fibers from both crura. This ring was friable and fibrotic for two centimeters from the margin except anteriorly, where the stretched opening extended into the area of the central tendon of the diaphragm. Here the margin was stronger and more nearly normal. The challenge for the surgeon is to close this ring so that esophageal reflux is controlled and the symptoms relieved.

### *The Descending Crura*

The descending diaphragmatic crura have been described as "strong, thick, musculo-tendinous bundles disposed vertically, the left being the smaller, shorter and the more posterior of the two. Each crus is fleshy laterally and strongly tendinous medially, the lower extremity being entirely tendinous" (Wood-Jones p. 834). Since the tendinous portion is the

From the Department of Anatomy, Emory University, and Piedmont Hospital.



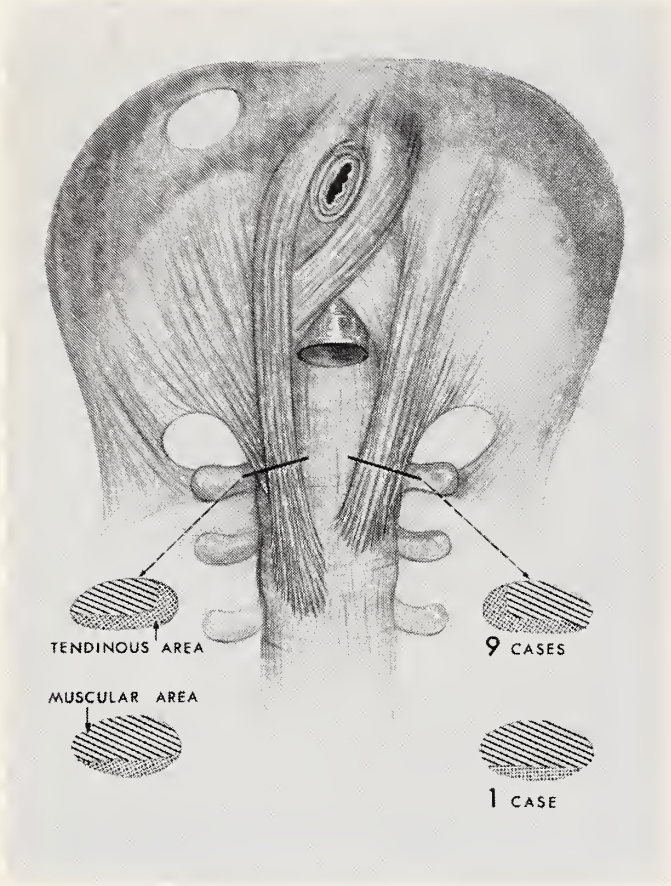


FIGURE I

The relative position of the tendinous and fleshy portions of the crurae at the level of the first lumbar vertebrae in ten cadavers with hiatal hernia.

strong part through which the surgeon must place his sutures when approximating the crura to narrow the enlarged hiatus, we paid special attention to its position and extent.

Among our cadavers with sliding hiatal hernia, examination of the crura at the level of the first lumbar vertebra showed some variation. In all, the posterior aspect of the crura was tendinous as would be expected from their posterior attachment to the vertebral bodies. The medial aspect was tendinous to a greater or lesser extent in nine of the ten cadavers. In one specimen the median aspect was fleshy and the posterior tendinous portion did not extend to the medial aspect. From the surgeon's view (anterior) there was no medial tendinous portion through which

he could have placed sutures. Figure 1 shows the relative position of the tendinous and fleshy portions of the crurae in our specimens.

Discussion

The authors believe that these observations of variation in the extent of the tendinous portions of the crura help explain the persistent ten percent recurrence rate in hiatal hernia repair. The presence of a medial tendinous region cannot be taken for granted. The crura must be carefully cleaned so that their thickness is appreciated and the location and extent of the tendinous portions clearly demonstrated. The space between the right crus and the inferior vena cava, which is filled with areolar and adipose tissue, must be especially well cleaned to expose the lateral margin of the crus and the medial wall of the vena cava. Care in completely exposing the crura will enable the surgeon to place his sutures through the tendinous portion rather than the muscular portion of each crus. We believe that such care will be repaid in a great reduction of the percentage of recurring hiatal hernia.

Summary

In repair of hiatal hernia the surgeon must not rely on the presence of normal anatomical structures such as the phreno-esophageal membrane or the median arcuate ligament. The hiatal ring itself may be greatly altered.

Special attention must be given to the location of the fibrous component of the descending crura so that sutures are not placed through the muscular component only. Failure to secure the fibrous portion of either crus can lead to recurrence of the hernia.

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# HEAD START CHILD DEVELOPMENT PROGRAMS

Avery Cotton, M.D., *Decatur*

Gerald H. Holman, M.D., *Augusta*

- A short outline of the projected program is presented and discussed.

THE HEAD START CHILD DEVELOPMENT programs were first conceived by the Office of Economic Opportunity and announced in February, 1965. These programs were put into effect July and August, 1965 through the Community Action Programs. The primary aim of Head Start was to reach the preschool child and his parents living in poverty and at first was designed for just one such two-month crash program. The over-all success of the program, however, demonstrated that this was a much needed and acceptable plan. Therefore, through Congressional mandate, the Head Start component of the War on Poverty has become an on-going program and is now being developed with three program categories available to those communities wishing them:

1. Follow-through programs including health, education, social service, and parent activities during the 1965-66 school year for those children who participated in HEAD START this last summer.
2. Full-year programs for preschool children three years of age or older.
3. Short-term programs this summer for children who will enter school in the fall of 1966.

Funds for Head Start programs will be provided through the Community Action Programs of the Office of Economic Opportunity. Up to 90% of the total cost will be thus provided, the local share of the cost, ten percent, may be made up either in cash or in kind. Applicants should, in planning their programs, consider use of funds from sources other than the Community Action Program of the Office of Economic Opportunity. The Elementary and Secondary Education Act, providing funds for public schools, is one major source; another is from the Children's Bureau under the Social Security Amendment of 1965. It is anticipated that communities will spend 20% to 30% of their total anti-poverty allotment on early childhood programs. These may include all three types of Head Start programs enumerated above. Communities wishing such programs for their deprived children may receive information from the Regional Office of Economic Opportunity on the total amounts available to them under the Community Action Program and other resources such as Title I mentioned above. Each community will do its own planning and decide how it will use its allotment. Any question regarding this should be directed

## PROJECT—HEADSTART

### SUMMARY OF THE WORK CARRIED OUT LAST SUMMER (FIGURES APPLY TO TOTAL CHILD DEVELOPMENT PROGRAMS)

State	Number Grants	Number Centers	Number Children	Federal Cost	Non-Federal Cost	Total Cost
Alabama .....	59	288	14,028	\$2,068,393	\$289,522	\$2,357,915
Florida .....	41	346	17,980	2,349,379	346,987	2,696,366
Georgia .....	100	379	18,588	2,898,508	406,511	3,305,019
Mississippi .....	46	284	21,347	4,152,242	427,684	4,579,926
South Carolina .....	39	262	13,840	1,933,891	222,088	2,155,979
Tennessee .....	67	761	28,183	4,120,910	512,257	4,633,167



## HEAD START / Cotton and Holman

to your office; address your queries to *Director, Head Start Program, Office of Economic Opportunity, 101 Marietta Street, Second Floor, Atlanta, Georgia 30303.*

During the summer of 1965 over 500,000 pre-school children from economically depressed families were given medical and dental examinations, and enrolled in a two to eight weeks child development and educational program. These programs were highly successful, reaching many more children than was anticipated and identifying considerably more dental and medical problems than had been foreseen.

### For the Whole Child

Head Start is a program designed for the whole child—not just his medical and dental care. The following are the areas that should be developed in each Head Start center:

1. Educational
2. Psychology
3. Social Welfare
4. Nutrition
5. Supervision of Play
6. Medical Care
7. Dental Care

This paper is presented to explain only the medical and dental aspects and to suggest how each program might be conceived and run by the community. The Professional Consultants in each of the above fields should be from the immediate community and should take part in the planning of and be responsible for programs in the center. If help is needed by a community in advising or supplying a professional consultant in any of the above fields, such can be obtained by writing your Regional Office in Atlanta, Georgia.

Most criticisms heard from physicians and dentists in this region regarding last summer's programs were mainly concerned with the fact that physicians and dentists were not consulted early in the planning phases of the individual local programs and that local medical societies and groups were not informed as to what were the goals of Head Start. This is written in an effort to overcome these faults. Local sponsors of child development programs should not begin a Head Start Center without first appointing a medical director. He should be asked to assist in planning the structure of that center. His ideas concerning the following should be particularly solicited:

1. Availability of personnel for consultation and emergency calls.
2. The necessity of a written permission form from each parent for supervision of each child's medical care.

3. His acceptance and endorsement of the medical guidelines for adequate medical screening of the participating children.
4. His endorsement of placing placards describing the emergency care of accidents and poisoning where they will be most readily available to the teacher or supervisor responsible for the daily care of the children.
5. The use of nurses aides and other health-related professional personnel in the screening of the children. A considerable portion of the screening of the children can be carried out by properly trained individuals and in each case their competence should be evaluated by the medical director of each Head Start Center.
6. His availability for health instructions to staff and parents plus his endorsement of the psychological, nutritional and medical record keeping of the center.
7. The time and place of the screening examinations and the conduct of the follow-up and emergency medical care of the children.
8. The time and place of immunization and laboratory screening procedures.

A dental director should also be consulted early in the program's planning, particularly as to the adequacy of the guide line to be followed in the dental examination, treatment and follow-up. The dentist should also decide to what extent health-related professional personnel should be used.

### Comprehensive Health Services

Communities should plan comprehensive health services for all HEAD START Child Development Programs. Funds from the Office of Economic Opportunity should be used only to meet those health needs that cannot be met effectively by existing local resources. Funds from the Office of Economic Opportunity should not be used to provide services to children from prosperous homes. HEAD START Child Development projects applying to the Office of Economic Opportunity for financing must submit a plan outlining how the project will utilize existing resources, provide comprehensive and coordinated care, maintain high quality standards, and involve the parents of the children in the project planning.

The applicant must show that all existing resources have been evaluated or are available locally to meet the health needs of these children. To do this it will be necessary to investigate local school health programs; financial assistance is available under both the 1965 amendments to the Social Security Act, the aid to dependent children programs, and state services for crippled children. It is also essential to check inpatient and out-patient facilities of public



and private hospitals, medical schools and teaching hospitals, and the local health department programs. The applicant should clearly and specifically show any deficiencies in utilization of existing health care resources. On the basis of this analysis, HEAD START programs can be planned to more effectively utilize existing resources and develop additional services as required. The HEAD START health program must provide comprehensive, continuous health care and supervision. It should contain appropriate means for coordinating all types of local health services and for planned interaction between health and other social services. The scope of the plan should include preventive, diagnostic, curative, and rehabilitative services for the children. The following at least should be arranged for—or provided directly with—the Office of Economic Opportunity's funds when they are not available through existing programs:

Overall health supervision of children who are well.

Immunizations.

Out-patient treatment of acute and chronic illnesses. Provision of follow-up care.

Comprehensive dental care, including preventive dental education.

Eye examinations as indicated by the medical director, including eye glasses if needed.

Speech and hearing examinations and provision of treatment, if needed.

Psychological evaluation and counseling.

High quality care can be assured only by gaining the participation and cooperation of qualified members of the medical, dental, psychological and nursing professions in the community. The plan must contain a means for assuring that follow-up services will be carried through. It is essential that continuing responsibility for the health needs of an individual child or family attending a Center must rest clearly with a single professional or a small, well-defined group of professionals. It is also essential that the staff of the HEAD START Child Development Center become the health advocate for the child. In this role the staff will see to it that needed services are actually available to the child and that the child, in turn, get any care required. The Center's nurse can act as liaison between parents, the Center, doctors and medical agencies. The nurse can also take the lead in teaching proper health habits and the rudiments of general standards of sanitation to both children and parents.

### Care Must Be Accessible

The health care to be provided must be made as accessible as possible by careful planning. Facilities and medical staff should be located in needy areas,

or transportation to reach them provided. Much of the program can actually be carried on at the HEAD START Child Development Center. This has the additional advantage of keeping the professional health staff actively involved in the continuing work of the Center. Services should be provided at hours convenient to the patients and their families. The plan should try to remove any existing barriers to proper health care, particularly the impersonal quality that so often characterizes health services available to the poor. So that there will be no misunderstanding about the diagnosis and need for further care, every effort should be made to encourage a parent to accompany the child on his visits for care.

It should be emphasized that the responsibility for providing and coordinating health services in any HEAD START plan must be in the hands of those with the professional competence to meet the high standards which have been set for the program. It is essential that a medical director be designated at the earliest possible moment in the planning stage. Health personnel and professional groups should also have a chance to take part in planning. This is important, since so many of the Center's services will come from them. Health services should be organized and coordinated to respond to the needs and desires of the groups to be served.

The agencies and personnel to meet these requirements will vary by community. They might include official health agencies, medical schools, voluntary and public hospitals and group practice prepayment plans and their staffs.

### Mobile Clinics

In some instances, where no physicians or dentists are available, it may be possible to send a medical or dental team into such an area in mobile clinics equipped with examination, laboratory and treatment facilities and manned by a physician, dentist and whatever health-related professions personnel deemed necessary by the local HEAD START medical director. It is estimated that each of the Southeastern region states will need from two to three such mobile units. The medical guidance in these cases could be secured from the nearest medical school and/or the nearest county medical and dental societies.

It should be specifically noted that a Head Start program is to be conceived, implemented and conducted by the Community which it serves. Organizations which had programs last summer or Community Action Agencies can apply for Head Start grants. In other localities any of the following may apply for funds:

1. Local health agencies
2. School boards
3. Colleges or universities



## HEAD START / Cotton and Holman

4. Private non-profit organizations (settlement houses, women's clubs, fraternal groups, charitable and religious organizations) and institutions of higher learning.

From this it is clearly seen that each program will

be organized and conducted by individuals living and practicing their professions in the community in which the center is located.

*Regional office of OEO and  
Department of Pediatrics  
Medical College of Georgia*

## GEORGIA'S FIRST TEMPORAL BONE BANK IS LOCATED AT EMORY UNIVERSITY

Emory University School of Medicine is the site of one of about 36 ear "banks" in the United States. The bank at Emory is the first in Georgia.

The "banks" are research laboratories where pathological studies of bequeathed inner ear structures are made. Information obtained in these studies is correlated with clinical data acquired during the donor's life.

The Deafness Research Foundation recently granted Dr. John H. Per-Lee, Assistant Professor in the school's Ear, Nose, and Throat Division, \$9,095 for operation of the Emory bank in 1966. Dr. John S. Turner, Jr. is director of the division and a co-investigator in the bone bank.

The bank is located in the Woodruff Memorial Research Building on the Emory campus. Personnel are now being trained to process specimens received by the bank. Dr. Per-Lee and other physicians will conduct the temporal bone pathology studies.

"We need temporal bones from persons with ear disorders of all types," Dr. Per-Lee said.

### Abnormal Only

Structures of persons with normal hearing are not needed. Those with the following disorders are asked to make bequests to the bank: Congenital deafness, hereditary deafness, deafness following childhood diseases, virus diseases affecting the ear, deafness of sudden onset, noise-induced deafness, otosclerosis (the formation of abnormal spongy bone around the stirrup or stapes bone of the middle ear), presbycusis (hearing loss related to the degeneration of aging) and Meniere's disease. Researchers are also interested in the bones of persons who suffer from labyrinthitis (inflammation of the labyrinth which causes dizzy spells), and other disorders of the balance mechanism.

Temporal bones of persons who have undergone ear surgery are also valuable to research. They provide im-

portant information about the effects of surgical procedures.

Associated with the banks are four regional centers which coordinate the acquisition, distribution, and medical documentation of the bequeathed ear structures following the death of the donor.

Completed pledge forms and medical histories of donors are kept in these regional centers: The Western Center at the University of California; the San Francisco Medical Center in San Francisco; the Southern Center at Baylor University in Houston, Texas; and the Midwestern Center at the University of Chicago, Chicago, Illinois. The Georgia bank is served by the center in Houston.

Dr. Per-Lee stressed that no cosmetic or facial disfigurement results from removal of the temporal bones, nor is there any cost to the donor, his estate or his survivors.

### A Pledge

The pledge to bequeath is signed by the donor, his next of kin, or by a chosen representative. Then the pledge, along with a signed release authorizing the donor's physician to release his medical and hearing history, is returned to the appropriate Temporal Bone Bank Center. If no hearing records are available, the Temporal Bone Banks Program can provide ear examinations to prospective donors. The donor retains and carries with him a wallet-sized identification and authorization card which states that his temporal bones have been bequeathed.

"The ultimate success of the program depends upon hearing-impaired Americans making available to scientists their inner ear structures and their medical and hearing records," Dr. Per-Lee said.

The Temporal Bone Banks Program for Ear Research has the support of the major medical organizations in the field, as well as that of various national agencies serving the deaf and hard of hearing.

## CYTOGENETICS LABORATORY OF ST. JOSEPH'S INFIRMARY EXPANDS FACILITIES

The Cytogenetics Laboratory of St. Joseph's Infirmary has obtained new and expanded facilities.

Chromosomal analyses are available to anyone desiring this type of study for both charity and private pa-

tients. Inquiries should be directed to the Department of Cytology, St. Joseph's Infirmary, JA. 5-4681, Ext. 273 or 274.



# COMMENTS ON MEDICARE . . . .

## Questions and Answers

Mr. Douglass M. Richard,\* *Atlanta*

IT'S ODD, ISN'T IT, that one could attend as many meetings of medical societies as I have during these past months—there have been dozens—and speak to as many physicians as I have—there have literally been hundreds—and yet never be asked the one question about Medicare and its administration that seems to be bothering practically every doctor? I say it has never been asked, and as a direct question it hasn't. But I've sensed it in the way many other questions were couched; I've felt it in the remarks made by many physicians.

So before we get into the questions and answers below, permit me a moment to ask this unasked question, and permit me a moment to answer it as truthfully and as sincerely as I can.

The question—and for clarity I'm phrasing it much more bluntly than physicians would ask it of me—is this:

“Do you bureaucrats think for one minute that you can transpose yourselves into the shoes of physicians, as it were, and even begin to imagine you ‘understand’ precisely how the physician feels, precisely what about the overall Medicare proposals bothers him most, and precisely what problems he sees in the future in his practice of medicine, problems accentuated by if not caused by Medicare?”

That's a long question. The answer is short. The answer is an emphatic, resounding “NO.” That's why we've been so anxious to meet with and talk with you. I don't profess to “know what it's like to be a doctor.” Of course not. I can't even imagine it. Not anymore than you, as physicians, can imagine what it's like to be involved on behalf of the government in the implementation of the Medicare program. And this, if you're still with me, leads to completion of the point I'm trying to make:

If it's true, as I've been saying to everyone who would listen, that Medicare is a physician-oriented

program, then it must follow that the program should reflect to the fullest extent possible the views of the physician. It serves little purpose, it seems to me, for us to debate at this point in time, whether Medicare should be here. It is. And because it is, and because all of us are so inextricably involved in one way or another, we need to be doing what we can do to continue to use and to strengthen the modes of communications that have been developed. To put it another way, we need to keep in touch.

I would hope that sometime in the next few months it might be possible to meet with you again, after we've had time to “accumulate a body of experience,” if I may use a little government gobbledygook. In the meantime, I would also hope that the intermediaries might have your cooperation as needed. In this way, among others, we'll help assure there will be an increasing reflection in Medicare's regulations of the views of organized medicine and of the individual physician. This seems to me of the utmost importance, and it's why I again make the point:

For the most part those of us in government aren't doctors and we well know it. Further, we don't have any hallucinations that we can imagine what it's like to be a physician. So we obviously need your help.

And now a word about the questions that follow. They are questions physicians asked me during question periods after talks I made to state and local medical societies. The answers given encompass all of the information available at the time this is prepared.

### 1. Q. Regarding the deductibles. Suppose the patient does not have \$40 or \$50?

A. The law specifies the deductible must be “incurred,” not paid. While we don't advertise this, for obvious reasons, it's a fact that the deductible need not be paid for the rest of the program to come into operation.

### 2. Q. Is a fee schedule for physicians going to be published?

\* Mr. Richard is Regional Representative, Bureau of Health Insurance, Social Security Administration, Atlanta.



## MEDICARE / Government Data

- A. No. We don't know at the moment exactly how the physicians and intermediaries will work together in passing information back and forth, but the "reasonable charges" determined for each physician will not be published.
- 3. Q. How is the Part B deductible to be handled?**
- A. We are going to encourage the beneficiaries to hold their bills until they have incurred at least \$50 before submitting to the intermediary. However, they won't do this in all cases, we know. It will be up to the intermediary to query the master tapes in Baltimore when he doesn't have the information at hand about the status of deductibles. As the beneficiary incurs costs under the program, he will be supplied with an updated statement by the intermediary which he will have available to submit to his physicians.
- 4. Q. About the \$50 deductible—must the deductible be paid annually, even if the patient won't visit a doctor during the entire year?**
- A. No. The deductible comes into the picture only when the patient begins to incur charges. Bear in mind the deductible is collectable by the doctor, not by the government. If, as you indicated, the beneficiary doesn't visit a doctor or otherwise incur charges under Part B for an entire year, the deductible, of course, would not come into the picture at all.
- 5. Q. If more than one doctor is involved in a case, from which one's bill will the \$50 deductible be withheld?**
- A. The intermediary will withhold from the first bill or bills submitted in the current year. There is no other practical way to do this. If this causes any particular problems, we will undoubtedly know about it soon enough!
- 6. Q. When a doctor accepts an assignment, will he know what the "reasonable charge" will be in advance of receipt of payment?**
- A. See answer to above question.
- 7. Q. Does the intermediary have to conduct a survey of "reasonable charges"?**
- A. No. The intermediaries were selected because they have an expertise in these matters. By and large we'll leave it up to the intermediary as to how he determines "reasonable charges." As a matter of fact, some intermediaries are conducting surveys of physicians now. Others are not.
- 8. Q. What are the basic hospital charges? What charges are not included?**
- A. Basically, the program covers roughly the same things as the average Blue Cross plans. We are talking here about room and board (semi-private rooms, and we caution you here that semi-private rooms are defined in the law as two, three, or four bed rooms, not two bed rooms only, as many of us are accustomed to thinking), the usual tests and x-rays, etc. Specifically not included are such luxuries as television and private rooms. However, if a private room is available, the patient may wish to get one and pay the difference between the semi-private and private rate himself. Private duty nursing is not included.
- 9. Q. Would not medical services on a utilization committee be a valid reason for charging the government?**
- A. Basically, costs that the hospital incurs in setting up and carrying out the utilization review program will be included in the determination of the "reasonable cost" to render services to Medicare patients. Thus, if the hospital pays a physician for his services on the committee, the "pay" could be included in the reasonable cost determination. One might wonder, however, how the physicians' acceptance of such payment would fit into the picture during a time when some medical societies are advocating that physicians should not, under any circumstances, be employees of hospitals. This, of course, is a matter for the individual physician to decide. Then, too, I understand physicians generally are not paid for time spent on tissue and other committees already operating. This might have a bearing on the physician's thinking about service on utilization review committees.
- 10. Q. Will the carrier be allowed to pay a different "reasonable fee" for the same services if rendered by a specialist or general practitioner?**
- A. Yes. If you consider that the carrier must take into consideration the customary fee of the individual physicians, as well as the prevailing fee in a given locality, you can see here that if the specialist has been receiving a higher fee than has the general practitioner, the same pattern would undoubtedly



be carried out under the Medicare program. The assumption would be that the specialist, by virtue of his extra training and particular experience, does and should demand a higher fee than the general practitioner. Of course, as is the case in most other facets of the remuneration determination, we now find general practitioners objecting to the philosophy on the grounds that by virtue of their long-time experience, they are often even more skillful than the young specialist. I suppose this indicates as much as anything the absolute need for medical societies to work with the intermediary in determining what has been the customary practice so that Medicare continues rather than disrupts past conditions.

**11. Q. What is the basis of payment to the intermediary?**

- A. There will be cost-no-fee contracts with the intermediaries. This means payment to the intermediaries will be determined on the basis of what it costs them to carry out the Medicare function, with no profit involved.

**12. Q. When will regulations concerning payments to hospital-based specialists be released?**

- A. The Principles of Reimbursement covering this have been released already. The law permits no payment by Part A to a physician for rendition of personal services to patients. This means his services to patients must be compensated for under Part B. As you know, though, the hospital-based physician often renders services that are not closely related to the care of the individual patient, such as teaching, research, and administration. These would be covered under the basic hospital insurance program. To cut down on a lot of paper work for the hospitals and hospital-based physicians the Principles would permit them to arrive at a determination jointly regarding what percentage of the physicians' services will be paid for under the supplementary medical insurance part of the law. This uniform percentage figure will need to be set at a level that is designed to allocate to the medical insurance program the same total amount of charges as would result from evaluating separately every service rendered to determine the medical and the hospital portions.

**13. Q. A recent issue of a national weekly magazine said (1) there must be no pay-**

**ment for a physical checkup in the physician's office and (2) no payment for relatives of physicians. Is this so?**

- A. The law prohibits payments for routine physical examinations. So that part's right. The law does specify that no payment may be made under Part A or Part B for any expenses incurred for services when such expenses are charges imposed by immediate relatives of or members of the household of the beneficiary. To that extent, then, payment couldn't be made for relatives of physicians.

**14. Q. If you once bill through the intermediary (accept assignment) are you in any way bound to continue to do so?**

- A. No. You may accept assignment in one case and bill directly in another. This is up to the physician. It seems reasonable to assume that some physicians will elect to accept assignment of bills of patients who have been "poor pay" in the past for one reason or the other, and bill directly on others. As I say, it's entirely up to the physician.

**15. Q. Has John Hancock Insurance Company contacted either the state or local medical societies as to reasonable charges in this state?**

- A. Yes. Furthermore, the Congress envisioned that the intermediaries would work quite closely with state and local medical societies in making these determinations, and we shall be requiring this of the intermediaries. However, it won't really be necessary to require it, as the intermediaries readily recognize that this is essential if the job is to be done in a fair manner. I would caution you, however, that the intermediary cannot under law subcontract or "abdicate" this function to medical societies. Obviously, there would then be little need for intermediaries. But again I would say to you, the intermediaries will be working very closely with the medical societies, and this highlights the need for cooperation across the board. John Hancock has been doing this and will continue to do so.

**16. Q. What form must a doctor execute to get his patient in the hospital under Part A?**

- A. The government is requiring no specific form. It will be up to the individual hospital to be able to state when billing the intermediary that the physician has certified as to the medical necessity of the admission. This is being worked out in a very simple



## MEDICARE / Government Data

manner, and I would imagine that the physician will see practically no deviation from his present methods of getting a patient in a hospital.

**17. Q. How much do you think Part B will really cost per month. \$10 or \$12?**

A. I guess what I think doesn't really matter very much. The fact of the matter is the actuaries working with the Congress figured \$3 a month by the beneficiary and \$3 by the government would do the trick for the first couple of years. As you know, the law dictates that the Congress itself must look at the financial status of Part B every two years to see whether the then current premium is sufficient.

**18. Q. Will one county resident be able to see a doctor in another county?**

A. Yes, he may see a doctor wherever he pleases. Incidentally, the bill will be submitted by the doctor or the beneficiary to the intermediary for the place in which the services are rendered. By and large this is on a geographical basis, in this part of the country by states. For example, if a doctor in Augusta renders services in North Augusta, South Carolina, the bill for those services would go to Blue Shield in Columbia, not to John Hancock. The situation would be similar if a Columbia doctor rendered services in Phenix City, Alabama. Railroad retirement beneficiaries will have a different procedure, though.

**19. Q. Since all Part B beneficiaries pay the same \$3 throughout the U.S.A., how can the reasonable fee vary by locality?**

A. We're confusing two separate and distinct things here. The \$3 is the amount the beneficiary pays. I guess you might say, the reasonable charge will vary and must vary under Medicare because it does, in fact, now vary in practice.

**20. Q. If I set my own fee and bill the patient and collect my own fee am I a "non-participating" doctor?**

A. As far as we are concerned, as far as the law is concerned, there is no such thing as a "non-participating" doctor. As has been indicated, the doctors have the legal prerogative of billing directly or of accepting assignment. There will be no group or class of doctors considered "non-participating" by the government. I would say this though:

any reasonable person would have to realize that there must be physician participation in the broad sense if Medicare is to work, for it will still take a physician to admit someone in the hospital. It will be the physician who will dictate the treatment. It will be the physician who will say whether the patient goes home or to an extended care facility, and it will even be the physician who says whether the rental of a wheel chair under Part B would be appropriate. This is obviously a physician-oriented program. So while in the narrow sense, physician participation isn't necessary (I'm talking here about billing directly), in the broad and general sense, it is absolutely essential.

**21. Q. Is a person under 65 on social security covered?**

A. No. Medicare covers only people 65 and over. I understand there is and will continue to be a strong movement to cover people who are drawing social security disability benefits, but this, of course, is a matter for Congress to decide.

**22. Q. If a hospital is "non-participating," can doctors still charge under Part B?**

A. I assume here you mean can a doctor charge under Part B for his treatment of a patient in a hospital which isn't under the Medicare program for one reason or another. He may. Title VI of the Civil Rights Act applies to hospitals and other providers of services under Part A, but it has been ruled that it does not apply in any way to Part B.

**23. Q. How can the Medicare patient obtain hospital care if none of the hospitals within a reasonable area are approved for Medicare?**

A. There is a provision in the law which permits us to approve some hospitals that do not otherwise qualify if those hospitals are the only ones in a given area to which a person has access. Even here, though, these "access" hospitals must be cleared under Title VI of the Civil Rights Act. As a practical matter, we believe that the vast majority of hospitals in the country will elect to take part in the problem, although not all of them may decide to do so by July 1. Someone has asked whether it would be possible under the program to pay for ambulance services to carry a patient to the nearest participating hospital. Frankly, we are not sure at the moment. This matter of



the extent to which ambulances may be paid for still hasn't been completely thrashed out. I hope we will know soon. Incidentally, there is provision for emergency in-patient care in non-participating hospitals but we would expect this to come into play infrequently if most hospitals participate.

**24. Q. Would payments to osteopaths and/or chiropractors count in the \$50 deductible? What about Christian Scientist readers?**

A. Payments to osteopaths in Georgia would count. The law defines a physician as a doctor of medicine or a doctor of osteopathy, licensed to do business in the state in which he practices. Chiropractors would not enter the picture in any way, nor would Christian Scientist readers.

**25. Q. Is there a provision for raising fees in keeping with so-called 3.2% government guidelines or is this a static fee?**

A. While there is no specific provision for raising fees, there is in the law the specific

requirement that the intermediary pay on the basis of a "reasonable charge." Quite obviously a reasonable charge today would not be the same for a given procedure as it would have been 20 years ago. The costs of practically everything, including medical care, have gone up. As the cost of living increases, then certainly the intermediary would have the responsibility of maintaining the payments to physicians on a reasonable charge basis, so the increased cost of living would be taken into consideration.

**26. Q. The request for payment form calls for the signature of the physician if he accepts assignment or uses the form as the itemized bill he gives the patient to submit directly. Must the physician sign the form himself?**

A. The intermediary will accept the doctor's usual practice. If he usually has his office assistant or nurse *sign* his name, that will be accepted. However, it must be *his* name, not the assistant's or nurse's. Printing of the name wouldn't serve the purpose.

## 1966 CALENDAR OF MEETINGS

### State

August 25-27—West Virginia State Medical Association, The Greenbrier, White Sulphur Springs, W. Va.

September 26-27—Tennessee Valley Medical Assembly, Trivoli Theater, Chattanooga, Tenn.

April 30-May 1-2, 1967—113th Annual Session of the Medical Association of Georgia, Marriott Motor Hotel, Atlanta.

### Regional

August 14-19—The Southeastern School of Alcohol Studies, The University of Georgia Center for Continuing Education, Athens.

August 18-20—Nineteenth Annual "Postgraduate Obstetric-Pediatric Seminar," sponsored by the Children's Bureau, Maternal Welfare Committees and Bureaus of Maternal and Child Health of the State Health Departments of Georgia, Alabama, Florida, Mississippi, South Carolina, and Tennessee at Daytona Beach, Fla.

August 24-26—Thirteenth Western Cardiac Conference, "Ischemic Heart Disease," University of Colorado Medical Center, Denver, Colo.

August 26—Medical Assembly of the Muscle Shoals Branch of the Alabama Chapter, American Academy of General Practice, Turtle Point Yacht and Country Club, Florence, Ala.

September 8-10—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.

September 16-17—Otolaryngology Seminar sponsored by the College of Medicine, University of Florida, J. Hillis Miller Health Center, Gainesville, Fla.

September 22-24—The American College of Cardiology Regional Meeting; and the Fifth Annual Cardiovascular Seminar, "Cardiovascular Emergencies," sponsored by the College of Medicine, University of Florida, J. Hillis Miller Health Center, Gainesville, Fla.

October 1-7—The Annual Otolaryngologic Assembly of 1966 sponsored by the Dept. of Otolaryngology of the College of Medicine of the University of Illinois, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

### National

August 12-13—National Conference on Infant Mortality sponsored by the American Medical Association's Committee on Maternal and Child Care, Fairmont Hotel, San Francisco.

September 15, 1966-June 15, 1967—Nine month tutorial program in Cardiology offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

October 7-14—American Academy of General Practice, War Memorial, Boston, Mass.

November 27-30—American Medical Association (Clinical Convention), Las Vegas, Nev.



# REQUEST FOR PAYMENT

## MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

■ Prepared for the Medical Association of Georgia by John Hancock Mutual Life Insurance Co.

THE KEY to the simplified procedure for requesting payment of medical insurance benefits under the voluntary Part B Medicare program is the "Request for Payment," form SSA-1490.


Developed by the Social Security Administration with the cooperation and guidance of the American Medical Association and the Health Insurance Industry, the form SSA-1490 (and form SSA-1490A, which is identical except that it has a snapout carbon copy), consists of three sections.

Heading, preprinted by the Part B Carrier to show the name, address and assigned number of that Carrier, and completed by the patient or his representative to show the patient's name, Health Insurance claim number, and sex.

The name and address of the Carrier identifies the Carrier designated to process Part B Medicare claims and pay benefits due under the program. The completed form should be sent to the address shown. Each carrier has an assigned number for further identification. The patient's name identifies the patient, and the claim number (in most instances the social security number plus a letter suffix), is essential for precise identity. The claim number is shown on the patient's Health Insurance card. It should be correctly entered on every form, bill, and other communication submitted to the Carrier, as benefits cannot be paid without it. The patient's sex is an important statistic.

Part I, to be completed by the patient, contains six questions:

- (1) **Description of illness or injury**  
If the patient's treatment is in connection with a non-occupational medical condition, Medicare benefits will, in all probability, be payable subject to the deductible and coinsurance amounts. However, the law does provide some exclusions and limitations and the patient's description of his illness or injury is important to determine the extent of benefits that may be due.
- (2) **Employment related**  
If the patient is entitled to benefits under a workmen's compensation law, Medicare benefits are excluded. Hence, the patient's answer to this question is essential to avoid a duplication of workmen's compensation benefits.
- (3) **Receipted bills**  
Part B Medicare benefits are payable to the patient, upon submission of receipted bill or bills, or to the physician or supplier to whom the patient assigns the benefits and who accepts that assignment.  
If the patient wants to pay his physician or supplier, and then submit paid bills and receive the Part B Medicare benefits, he should answer this question by checking the "Yes" box.

 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION	<b>REQUEST FOR PAYMENT</b> MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (Type or Print all Information)	Form Approved. Budget Bureau No. 72-R730
John Hancock Mutual Life Insurance Co. 230 Houston Street, N. E. P. O. Box 1632 Atlanta, Georgia 30301	Copy from your HEALTH INSURANCE CARD ➔	NAME OF BENEFICIARY (Patient) John Q. Public CLAIM NUMBER 000-000-0000-A. <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE



(4) **Assignment**  
If the patient wants payment to be made to the physician or supplier, he should check the "Yes" box here. Then, if the physician or supplier accepts the assignment, benefits due will be paid directly to the physician or supplier.

(5-6) **Patient's signature, date, address and telephone number**  
These items are essential to formalize the patient's request for payment and furnish additional identifying information.

program. As a further identification of the exact procedures, adding the physician's customary procedure code to the description, as well as a copy of the operative notes when unusual or complicated surgery is involved, will expedite the payment.

(7D) **Nature of illness or injury.** It is essential that the physician describe each condition for which he treated the patient and for which he furnished the services and supplies, as an additional basis for determining the program's coverage and benefits pay-

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.


1. Describe the illness or injury for which you received treatment. (You do not need to complete this item if your doctor completes Part II below)

Bronchial Pneumonia

2. Was your illness or injury connected with your employment? ☐ YES ☒ NO

3. Are you attaching itemized receipted bills? ☐ YES ☒ NO

4. ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier? ☒ YES ☐ NO  
AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.  
REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

5. SIGNATURE (Patient or authorized repr. representative)	DATE SIGNED
	8-1-66
6. ADDRESS (Street address, City, State, ZIP Code)	TELEPHONE NUMBER
16 Main Street, Atlanta, Georgia 30301	577-4000

Part II, completed by the physician or supplier, contains seven questions:

(If itemized paid bills are submitted, they must contain the same information that is asked for in this part.)

(7A) **Date of each service.** It is essential that the date of each service or supply be shown here so that consideration can be given to each. Benefits are not payable for services furnished before the effective date of the patient's coverage, or after the patient's coverage terminates.

(7B) **Place of service.** This information (as shown in the code at the bottom of the form), will help to determine the reasonableness of a particular charge, as well as furnish statistical information regarding the type of health care furnished.

(7C) **Description of services.** The physician or supplier should fully describe the surgical or medical procedures and other services and supplies furnished, as this information is an important factor in determining their coverage and benefits payable under the

able. It is particularly important to note any mental disorder for which out-of-hospital treatment was furnished.

(7E) **Charges.** Itemized charges for each of the services or supplies described in Item 7C, for each date shown in Item 7A, are necessary to determine the amount of benefits payable.

(8) **Name and address.** The physician's or supplier's name and address must be entered here, to permit payment of benefits due.

**Telephone number.** This is important in the event the carrier should need to contact your office for additional or explanatory information to hasten benefit determination.

**Code number.** Physician's state license number should always be entered here, as additional identification.

(9) **Total charges.**

(10) **Amount paid.**




PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, Including Physician's Signature, Need Not Be Completed If Paid, Item Bills Are Submitted.

7. A. DATE OF EACH SERVICE	B. PLACE OF SERVICE <sup>1</sup>	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (Diagnosis)	E. CHARGES	Fee Blot
7-10-66	IH	tracheotomy (2101)	bronchial pneumonia	\$ 50.00	
7-15-66	H	medical treatment	bronchial pneumonia	6.00	
7-20-66	H	medical treatment	bronchial pneumonia	6.00	
7-25-66	O	medical treatment	bronchial pneumonia	6.00	

8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number and street, City, State, ZIP Code)  Robert Smith 65 Basin Street Atlanta, Georgia 30301	TELEPHONE NUMBER  577-1000	9. Total Charges	\$ 68.00
	CODE NO.  1234	10. Amount Paid	\$ -----
		11. Any Unpaid Balance Due	\$ 68.00

12. ASSIGNMENT OF PATIENT'S BILL (See reverse) ☒ I ACCEPT ASSIGNMENT ☐ I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)  
 Robert Smith

☒ MD ☐ DO ☐ DDS OR DMD

DATE SIGNED 8-1-66

<sup>1</sup>O—Doctor's Office      IH—Inpatient Hospital      ECF—Extended Care Facility      OL—Other Locations (Specify in 7C)  
IL—Independent Laboratory (give name and address in 7C)      H—Patient's Home      OH—Outpatient Hospital      NH—Nursing Home

FORM SSA-1490 (4-66)

Paid bills containing all the information requested in Part II, including procedure code and state license number, may be submitted in lieu of completing Part II.

Robert Smith, M.D.  
65 Basin Street  
Atlanta, Georgia 30301

PAID 8-15-66  
R. Smith, M.D.

Telephone 577-1000

License No. 1234

To  
Mr. John Q. Public  
16 Main Street  
Atlanta, Georgia 30301

August 1, 1966

Diagnosis - Bronchial Pneumonia

Surgical Procedure: Tracheotomy (2101)

Medical Treatments: in hospital 7-10-66 \$50.00  
Patient's home 7-15-66 and 7-20-66 2@6 12.00  
Office 7-25-66 1@6 6.00

\* Additions required



(11) **Any unpaid balance due.** When a part of the charges has been paid and the patient assigns benefits to pay for the unpaid balance, it is necessary for the physician or supplier to indicate the amount of the unpaid balance, so that the carrier can pay the correct amount to the physician or supplier, and any balance to the patient.

(12) **Assignment.** If the patient wants payment for an unpaid bill to be made directly to the physician or supplier, he will so indicate in line 4 of Part I. To complete the assignment, however, the physician or supplier must indicate his acceptance of the assignment here. If the patient assigns his benefits to the physician or supplier and the latter accepts the assignment, then benefits due will be paid directly to the assignee. Under the assignment method of payment, the physician or supplier who accepts an assignment also agrees to accept as his full charge the charge determined by the carrier to be the reasonable charge. The patient is then responsible for only the deductible and coinsurance amounts.

(13) **Signature, professional degree, date.** This information completes the physician's

or supplier's formalized request for payment.

A separate Request for Payment must be used by each physician or supplier requesting payment under the Assignment method.

The Request for Payment form will be furnished initially to each Part B beneficiary with his Medicare Handbook, and the Carrier will send a blank form to him after each non-assignment payment is made. The Carrier will furnish each physician with a supply of the form, and you should be receiving a supply around June 15, 1966. Additional forms will be furnished to you on request.

The physician or supplier should mail the completed Request for Payment to the Carrier designated by the Secretary of Health, Education and Welfare to handle medical insurance benefits in the area where the covered services or supplies are furnished. In the state of Georgia, the John Hancock Mutual Life Insurance Company is that Carrier, with offices in the new John Hancock building located at:

*Medicare—Part B  
John Hancock Mutual Life  
Insurance Company  
230 Houston Street, N. E.  
P. O. Box 1632  
Atlanta, Georgia 30301  
Telephone 404 577-4410*

## GEORGIA DOCTORS ATTEND SUCCESSFUL AMPAC WORKSHOP

The American Medical Political Action Committee (AMPAC) scored another success at its annual National Workshop meeting in Washington, D. C. in May.

The Workshop was attended by five or more representatives from every state in the union. Seven representatives from GaMPAC were present and by common agreement the political IQ of each of them was elevated several points at the conclusion of the meeting.

### Campaign Techniques

The Workshop was designed to give members of the various State Political Action Committees the benefit of the latest, most modern campaign techniques devised by some of the sharpest political pros in the business. Campaign fundamentals were also stressed by the impressive array of talented speakers on the program.

The real highlight of the two-day meeting was a lengthy presentation by a crack public relations firm from Los Angeles who only recently managed the successful California gubernatorial primary contest of Republican hopeful Ronald Reagan. Such was the caliber of the program throughout.

Unveiled for the first time for most of those present were the mysteries of such campaign techniques as opinion surveys, political data processing via computer, campaign management, fund raising, how to handle the press, and a host of other devices, the employment of

which is so vital to any successful campaign.

Everyone who attends these annual Workshop meetings comes away impressed by the thoroughly professional status which AMPAC has achieved in four short years. Since 1962 it has grown from absolute zero to a position of preeminence among professional groups working in the field of political activity.

## ELEVENTH IN SERIES OF TV PROGRAMS PRESENTED BY GEORGIA HEART ASSN

The eleventh in the current series of television programs presented by the Georgia Heart Association for physicians will be seen August 1-2 on the Georgia Education Television Network. It is entitled, "Vascular Disease of the Central Nervous System." Guest Faculty: Fred Plum, M.D., Anne Parrish Titzell Professor of Neurology, Cornell University Medical College; Fletcher H. McDowell, M.D., Associate Professor of Medicine (Neurology), Cornell University Medical College; and Russel H. Patterson, Jr., M.D., Clinical Instructor in Surgery, Cornell University Medical College, Ithaca, New York.

A part of the "Georgia Heart Hour" series, this program will be telecast from 10:30-11:30 p.m., Monday, August 1 and repeated at the same time on Tuesday, August 2.



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in diarrhea

LOMOTIL<sup>®</sup> Tablets  
Liquid

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride . . . . . 2.5 mg.

(Warning: May be habit forming)

atropine sulfate . . . . . 0.025 mg.



is a corker

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**Effectiveness:** Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

**Convenience:** Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

**Versatility:** The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

**Dosage:** For full therapeutic effect — Rx full therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

**Children:** 3 to 6 months — 3 mg. (½ tsp.\* t.i.d.)  
6 to 12 months — 4 mg. (½ tsp. q.i.d.)  
1 to 2 years — 5 mg. (½ tsp. 5 times daily)  
2 to 5 years — 6 mg. (1 tsp. t.i.d.)  
5 to 8 years — 8 mg. (1 tsp. q.i.d.)  
8 to 12 years — 10 mg. (1 tsp. 5 times daily)

**Adults:** 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

\*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the therapeutic dose.

**Precautions:** Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdose.

**Side Effects:** Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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**SEARLE**

*Research in the Service of Medicine*

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# ROLE OF THE "CARRIER" UNDER MEDICARE PART B—PHYSICIANS' SERVICES

Mr. Lawrence B. Gilman, *Boston, Massachusetts\**

**J**UST A FEW WORDS about the Company which I represent and which will be your Carrier for Part B—the voluntary part which concerns itself with doctors' services and other medical services and supplies. The John Hancock has been in business more than 103 years, its assets are in excess of eight billion, and it is the fourth largest carrier in the country in terms of insurance in force. Our address in Atlanta for Medicare will be the first and second floors of the John Hancock Building, 230 Houston Street, N.E., P. O. Box 1632, close to the Expressway—Telephone 577-4410.

## The Challenge

What then is the challenge that lies ahead for the Part B Carrier? It has been said to consist of three parts.

1. Can the federal government and the carriers, representing the private sector of the insurance field, work together effectively on a contractual basis with a sharing of the administrative tasks?

2. Can carriers, acting in the role of government representatives, work as effectively, and more so than in the past, with the medical world?

3. Can the tri-partite arrangement—government, doctor and carrier—be so merged as to produce an efficient and effective claims administration process which will meet the test of enhancing quality medical care with accountability to the Congress and the American people?

In the background of this Public Law 89-97, several points should not be overlooked. The first of these is that Congress clearly felt that the handling of claims arising from physicians' services would be most effective if it utilized existing organizations with whom physicians had customarily dealt as part of the process of satisfying claims of insured patients.

\*Mr. Gilman is Vice-President, John Hancock Mutual Life Insurance Company, Boston.

Presented at the 112th Annual Session of the Medical Association of Georgia, May 9, 1966, Columbus, Georgia.

Our role, as we are told, is looked upon basically as that of an "intermediary" or "carrier" between the government and the providers of service, between government and physician—rather than a carrier between the Social Security Administration and the eligible beneficiary.

Another point seems to be that in the words of the United States Senate Committee of Finance report,

"In the performance of this contractual undertaking, the carriers and fiscal intermediaries would act on behalf of the Secretary, carrying on for him the governmental administration responsibilities imposed by the bill. The Secretary, however, would be the real party in interest in the administration of the program, and the Government would be expected to safeguard the interests of his contractual representatives with respect to their actions in the fulfillment of commitments under the contracts and agreements entered into by them with the Secretary."

I hope you will agree with me that, while our Part B role is one of carrying out assigned tasks specifically authorized by contract, both now and for the immediate future, this contract between government and ourselves in its assigned responsibilities constitutes a grant of authority to act with initiative, energy, creativity, and considerable independence.

Before we concentrate on the overriding objective of the Part B Carrier—prompt, effective and efficient claims processing compatible with existing medical practice, I might make, perhaps, one more general point.

## A Variety of Tasks

The Part B Carrier will perform a variety of tasks relating to partial reimbursement of covered services rendered within the geographical areas assigned to it—in this case, the State of Georgia. In the light of the primary orientation towards physicians rather than beneficiaries, we will handle claims based on



where the service is rendered rather than where the beneficiary resides. Claims for services rendered in Georgia should be sent us even if the beneficiary involved resides in an area served by another carrier. The effect of this is to avoid a multiplicity of carriers making determinations of reasonable charges as to the services of an individual physician.

I think it might be helpful to very generally give you an overview of the claims process with perhaps a little emphasis on those areas where the carrier role particularly impinges on the physician community. From your point of view, the work of the Part B Carrier relative to its claims function may be divided into at least nine broad categories:

1. Eligibility,
2. Covered Services,
3. Uncovered Services,
4. The controls of deductibles, co-insurance, and psychiatric limitation,
5. The request for payment,
6. Review and hearings,
7. Medical Society Review Committees,
8. Collection of Part B statistics, and finally,
9. The Subject of what are reasonable charges.

**1. Eligibility and Deductible Status**—The Part B Carrier is not the repository of any information as to eligibility nor does it play any function in the collection of the required \$3 premium. It does, however, on the receipt of any request for payment, act as the inquirer of the Master File at Social Security, Baltimore, until satisfaction of the status of the deductible amount or the current paid out amount for psychiatric benefits of a beneficiary for Part B payments. Social Security Administration has established a magnetic tape record for each individual enrolled for Part B. As a carrier, we will communicate with these tape records from our Atlanta office via wire transmission. When an individual becomes entitled to health insurance benefits, he receives a Health Insurance Card with his name, sex, HI claim number and effective dates of entitlement to both hospital insurance and medical insurance, if any. The individual, or for him, his physician or other supplier, *must*, repeat *must*, show the HI claim number on the Request for Payment form and bills sent to the Carrier, for all SSA records are maintained by the individual's HI claim number.

**2. Covered services**—The statute permits carrier payment for the reasonable and necessary physician services on a reasonable charge basis with itemized receipted bills or on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service. These bills must show the date, place services were provided, diagnosis and charges. These charges may properly include items

and services customarily furnished by the physician as incidental to his services and included in his bill.

Just a word as to other medical and health services—and on a reasonable charge or reasonable cost basis for:

Diagnostic x-ray tests, diagnostic laboratory test, and other diagnostic tests unless covered by Part A hospital insurance.

X-ray, radium and radioactive isotope therapy, including materials and services of technicians.

Certain services and items furnished by an independent laboratory. To be covered, the independent laboratory must be licensed by the state or approved by the state as meeting standards for licensing, and must meet other health and safety standards required by the Secretary.

Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations.

Prosthetic devices (other than dental) which replace all or part of an internal body organ, including replacement of such devices.

Leg, arm, back, and neck braces and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

Rental of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheel chairs used in the patient's home (including an institution used as his home).

Ambulance service where the use of other methods of transportation is contraindicated by the individual's condition as provided in regulations.

Services and supplies such as are commonly furnished in physicians' offices or included in physicians' bills, which are furnished as an incident to a physician's professional service, and hospital services not paid for under Part A incident to physicians' services rendered to out-patients: including drugs and biologicals which cannot be self-administered.

It should be noted that our Company is not, repeat is not, the carrier for any part of the Home Health Services either in connection with or not in connection with prior hospitalization. It is not that we have any aversion to such an undertaking, but the time in order to tool up to do any more than we have already undertaken was just too short.

**3. Non-covered services**—Services and items not reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member.

Service or items which are paid for directly or indirectly by a governmental entity, except in such cases as the Secretary may specify.

Services for which the patient has no legal obligation to pay (free chest x-rays).



## MEDICARE / Carrier Data

Services furnished by immediate relatives or members of the same household.

Services of chiropractors, naturopaths, chiropractists, podiatrists, optometrists, or Christian Science Practitioners.

Cosmetic surgery (except for prompt repair of accidental injury or for improvement of the functioning of a malformed body member).

Dental services (except dental surgery to jawbone or contiguous structure).

1. Custodial care.
2. Routine physical examinations.
3. Immunizations.
4. Examinations for fitting eyeglasses, hearing aids.
5. Eyeglasses, hearing aids.
6. Dentures, orthopedic shoes.
7. Prescription drugs.
8. Personal comfort items.

A service or item which may be reimbursed under Part A or under a Workmen's Compensation Plan cannot be paid for under Part B.

**4. The Controls of Deductibles, Co-insurance and Psychiatric Limitation**—In each calendar year, the first \$50 of covered medical insurance expenses are not paid for. Expenses incurred in the last three months of the previous year, which were used toward the Part B deductible for that year, may also be applied against the deductible for the current year. The date of service determines when expenses were incurred. Expenses will be allocated to the deductible in the order in which the bills for these expenses are received. After the deductible has been satisfied, the program will pay 80% of the reasonable charges incurred during the balance of the calendar year. The remaining 20% is the responsibility of the patient. Regardless of the actual expenses incurred for treatment for mental, psychoneurotic or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62½% of the actual expense. The qualification of the practitioner as a psychiatrist is not necessary for the purposes of the limitation.

**5. Request for Payment**—There will be two ways to claim payment for medical services. The same form will be used for either method.

Under one method, the doctor will bill the patient, and after the patient has paid the bill, the patient will claim reimbursement. Under the other method, if the doctor and patient agree, the doctor will send in the claim and receive payment. This method of requesting payment can be used where all or any part of a medical bill still remains to be paid.

Under the payment to patient method, the patient will fill in the top half of the form and attach the doctor's itemized receipted bills. He will need to ask the doctor to fill out the bottom half of the form only if the receipted bills do not give the necessary basic facts about the services supplied and when and where they were furnished.

Under the payment to doctor method to be used when all or any part of a medical bill has not yet been paid, the patient will fill in the top half of the "Request for Payment" form and give the form to the doctor. The doctor will fill in the bottom half of the form and send the form to the organization which will be handling medical insurance benefits in that area of the country.

If the payment to doctor method is used, the doctor agrees to accept the amount paid to him by the medical insurance program as 80% of his total bill, over and above the \$50 deductible amount—that he will collect from the patient no more than the remaining 20%, plus any part of the \$50 deductible still owing him.

A sample form and a copy that the over 65 person can use in making his first claim was included in "Your Medicare Handbook," a detailed instruction book that was mailed in June to all persons entitled to hospital insurance and medical insurance benefits under the Medicare program.

Additional copies of the forms will be available at physicians' offices and all Social Security offices, and at offices of the organizations in each area who have been selected to receive and pay bills under the Medical insurance program.

In the part to be completed by you, where it has the caption—"Fully Describe Surgical or Medical Procedures," it would be appreciated that if a standard coding and nomenclature guide is adopted by the AMA, that the code for the service be incorporated in addition to the description. Also where the form calls for "Code No.," please use your Georgia physician license number. If the receipted bill route is used and you do not want to fill out Part 2 of the Request for Payment form, please be sure on the itemized receipted bills that, in addition to all the other statement of facts required, if standard coding and nomenclature is adopted, you use both and your Georgia physician license number.

**6. Review and hearings**—One of the important functions of a carrier is to notify each beneficiary of the action taken on his Request for Payment, whether submitted directly or by a doctor accepting assignment. The notice is needed to explain the transaction to the beneficiary and to give him the opportunity to appeal the determination. The law requires that carriers provide a fair hearing for any enrolled person when a request for payment is de-



nied, or not acted upon with reasonable promptness, or when the amount of payment is in controversy.

**7. Medical Society Review Committees**—We have begun talking with your Society about how to handle problem claims which we hope will be few in number. We would like to work out with you a local and state medical review committee structure which might most efficiently handle questions involving the reasonableness of charges and other problems.

**8. Collection of Part B Statistics**—The Health Insurance Program for the Aged will have a great impact on the organization and financing of medical care services in this country, on the number and kinds of health care facilities and personnel, and on the amount and kinds of health services utilized by the aged, as well as by other age groups. At the same time, the program will offer a means of obtaining complete, systematic, and continuous information about the amount, kind and cost of health care services used by the aged as a by-product of benefit payment operations. Basic program statistics will be compiled by the SSA from a continuous sample of bills that carriers will send to Baltimore.

**9. Reasonable Charges and the Payment Procedure**—The act contains two basic criteria for determining reasonable charges: (1) the customary charges for similar services generally made by the physician or other person furnishing the service, and (2) the prevailing charges for similar services in the locality. In no event, however, can the reasonable charge be higher than the charge applicable for a comparable service under comparable circumstances to the policyholders of the intermediary. The phrase "applicable charge," however, does not mean the amount the carrier would actually pay, but the charge on which it would base its payments. Many carriers pay less than "reasonable charges" on the basis of deductibles and co-insurance.

It doesn't sound too different from a statement adopted by the House of Delegates of the American Medical Association at New York City, June 20-24, 1965:

"It is recommended that when government assumes financial responsibility for an individual's

health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. Therefore, reimbursement for the services of physicians participating in government supported programs should be on the basis of usual and customary fees."

Also during the AMA Reference Committee Hearing, it was reported that the California Medical Association recently adopted the following for the terms "Usual," "Customary," and "Reasonable Fee";

*"Usual*—the 'Usual' fee is that fee usually charged for a given service by an individual physician to his private patient i.e., his own usual fee). *Customary*—a fee is 'Customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county). *Reasonable*—a fee is 'Reasonable' when it meets the above two criteria, or in the opinion of the responsible medical association's review committee, is justifiable, considering the special circumstances of the particular case in question."

Where the law uses the word "Customary," it equates the word "usual" as here defined, and where the law uses the word "prevailing" it is the equivalent of "customary" as here defined.

Finally, I would like you to know that we will be attempting to render to the Senior Citizens of this state an effective, sensitive and efficient administration of Part B, if we are finally chosen as the Intermediary, and we will be looking forward to working with you in the matter of application of controls so that Medicare will not provide the opportunity either to escalate charges or to suggest unnecessary utilization of services. We, together, have a grave responsibility to see that this adventure neither wholly public nor wholly private, succeeds, so that quality medical care for our aged is indeed enhanced in the years ahead.

## GRANT AWARDED TO ST. JOSEPH'S INFIRMARY DEPARTMENT OF CYTOLOGY

The Department of Cytology, St. Joseph's Infirmary, has been awarded a U. S. Public Health Service grant for the training of cytotechnologists. This is a continuation grant which has in the past enabled the depart-

ment to train more than 40 cytotechnologists. The prerequisite for training is two years of college and one year of training in the laboratory. Scholarships are available to students under the grant funds.



## **REPORT OF MAG MEDICAL REVIEW AND NEGOTIATING COMMITTEE**

**W**ITHIN A FEW DAYS after announcement of appointment of the John Hancock Mutual Life Insurance Company as carrier for Part B of the medical insurance program in Georgia, officers of MAG were in communication with representatives of the company. Arrangements subsequently were made for the MAG Medical Review and Negotiating Committee to meet with these representatives to pursue further the possibility of working with the carrier toward developing a mutually agreeable plan for reimbursement of Georgia physicians on the basis of usual and customary charges.

During the next several weeks meetings of the entire Medical Review and Negotiating Committee were held on April 24, May 1, and May 15, and a meeting of a subcommittee was held on April 28. Representatives of John Hancock were present at each of these meetings. The final result of these many hours of conference is the "Proposed Policy of MAG Medical Review and Negotiating Committee" which is reproduced below in its entirety.

The Committee felt that it would be unwise to attempt a geographic "breakdown" of the state for evaluation of physician's charges and also felt that a state-wide questionnaire survey of physician's charges would not be necessary, since the physician's own charges, as presented on the claim forms, would very shortly establish sufficient experience data. For purposes of obtaining a maximum figure, above which any claim would be subject to medical review, it was thought that these maximum figures could be more appropriately obtained from the individual societies comprising the membership of the Medical Review and Negotiating Committee.

During all of the above mentioned meetings there was a very fine spirit of understanding and cooperation on the part of all persons involved, and it is believed that the John Hancock Company will continue to work diligently to administer a program acceptable to Georgia doctors and beneficial to Georgia patients.

*Henry S. Jennings, Jr., M.D., Chairman  
MAG Medical Review and  
Negotiating Committee*

### **PROPOSED POLICY OF MAG MEDICAL REVIEW AND NEGOTIATING COMMITTEE IN RELATION TO ADMINISTRATION OF THE NEW "MEDICARE" LAW AS IT AFFECTS PHYSICIAN'S REIMBURSEMENT**

#### **(1) Reimbursement of Physicians for Services Rendered:**

It is strongly recommended that when government assumes financial responsibilities for an individual's health care, reimbursement for professional services by the Carrier should be on the same basis as in the case of other indispensable elements of health care.

*THEREFORE, reimbursement for the services and supplies of physicians participation in government supported programs should be on the basis of usual and customary fees.*

#### **(2) Usual and Customary as Reasonable Fees:**

It is further recommended that consideration be given the following definitions in rules and regulations of the Carrier governing the administration of physician reimbursement under the provisions of P.L. 89-97, the Medicare Law.

**USUAL**—The "usual" fee is that fee usually charged, for a given service, by an individual physician to his private patient (i.e. his own usual fee). ("Customary" is the Medicare terminology for this definition.)

**CUSTOMARY**—A fee is "customary" when it is within the range of usual fees charged by physicians of similar training or experience within the community. ("Prevailing" is the Medicare terminology for this definition.)

**REASONABLE**—A fee is "reasonable" when it meets the above two criteria, or in the opinion of the responsible review committee, and the Carrier, is justifiable considering the circumstances of the particular case in question.

*THEREFORE, all physicians will be requested to*



submit their usual and customary charges in this program.

### **(3) Legal Regulation Imposed on Carrier:**

It is understood that the Social Security Administration requires that the Carrier administering Part B, Physician's Services, P.L. 89-97, in the reimbursement of physicians, must also be guided by two other factors in addition to the concept of "usual" charge; namely, (1) the prevailing charges for services within the community and (2) the charges for comparable services under comparable circumstances recognized by the Carrier for its own policyholders.

*THEREFORE, claims not falling within usual, customary, reasonable and/or legal criteria will be submitted to Review Committees unless additional information secured by the Carrier from the physician results in a mutually agreeable disposition of the claim.*

### **(4) Medical Consultant to Carrier:**

It is recommended that the Medical Association of Georgia Executive Committee of Council submit the names and qualification of four (4) physicians to the Carrier for consideration for the position of "Medical Consultant" to the Carrier; the terms of such employment by the Carrier to be set by the Carrier and the physician selected by them. The Medical Consultant would be directly responsible to the Carrier, but would also serve the Carrier as liaison between the Carrier and the Association.

### **(5) Medical Review Committee Procedures:**

It is understood that the Carrier must retain the right and responsibility for all decisions in regard to the payment of all claims for reimbursement of physician's services. However, it is recommended that the Carrier utilize Medical Review Committees on the following basis for "problem claims," and adjudications of unusual circumstances, complications, and supplementary skills.

#### **(A) County Medical Society Review Committees**

- (1) Atlanta/Fulton County Medical Society
- (2) Augusta/Richmond County Medical Society
- (3) Savannah/Georgia Medical Society
- (4) Columbus/Muscogee County Medical
- (5) Macon/Bibb County Medical Society
- (6) Decatur-DeKalb/DeKalb County Medical Society

#### **(B) District Medical Society Review Committees**

- (1) 1st District Medical Society
- (2) 2nd District Medical Society

- (3) 3rd District Medical Society
- (4) 6th District Medical Society
- (5) 7th District Medical Society
- (6) 8th District Medical Society
- (7) 9th District Medical Society
- (8) 10th District Medical Society

The method of appointment of the Review Committee is to be determined later if the mechanism of Review is approved.

"Problem Claims" from physicians who are members of one of the designated County Medical Societies would be forwarded for review to that physician's County Society Review Committee and claims for physicians from other than one of the designated County Societies would be forwarded to the designated District Medical Society Review Committee appropriate to the area of the physician's membership.

It is recommended that the Carrier in consultation with their Medical Consultant devise a procedure mutually agreeable to the Carrier and the Association whereby "problem claims" are first considered by the Carrier and the Medical Consultant and secondly, if necessary, forwarded to Review Committees by the Medical Consultant for recommendations. Similarly, operational guidelines for the function of Review Committees will be developed. The recommendation for the Review Committees along with the problem claim would then be returned to the Medical Consultant for advisement with the Carrier as to final disposition.

It is recommended that a State Review Board, to be composed of the MAG Medical Review and Negotiating Committee members, also be set up for the use of the Medical Consultant and the Carrier for those claims which have been reviewed by Review Committees—but which, in the judgment of the Medical Consultant and Carrier need further review prior to final disposition.

And it is further recommended that an "Appeals Committee" which could be the State Review Board, to include representatives of the Association, the Carrier and the Medical Consultant, be set up so as to provide for hearings of actual cases at the request of the physician or the Carrier or the Review Committee involved in the disposition of the claim.

Physicians will be notified of their right to appeal.

### **(6) Carrier-MAG Consultation:**

It is also recommended that the Carrier and the appropriate MAG Committee join together, at regular intervals (not to exceed one year), for the review and revision of procedures and policies.



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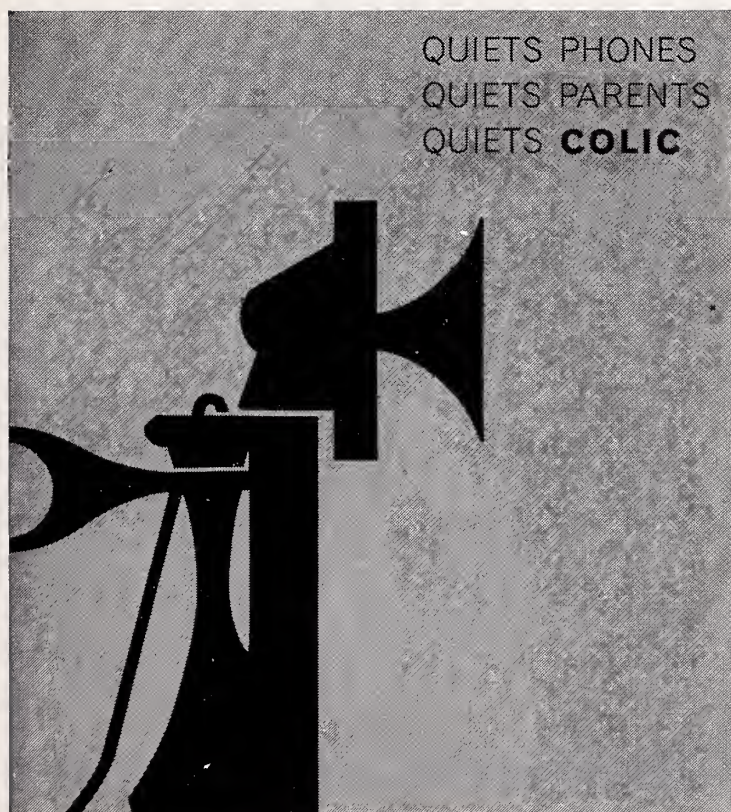
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190  
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## **METATENSIN®**

Each scored tablet contains:  
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2 mg. or 4 mg. and  
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**Usual adult dose:** One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

**Contraindications:** Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

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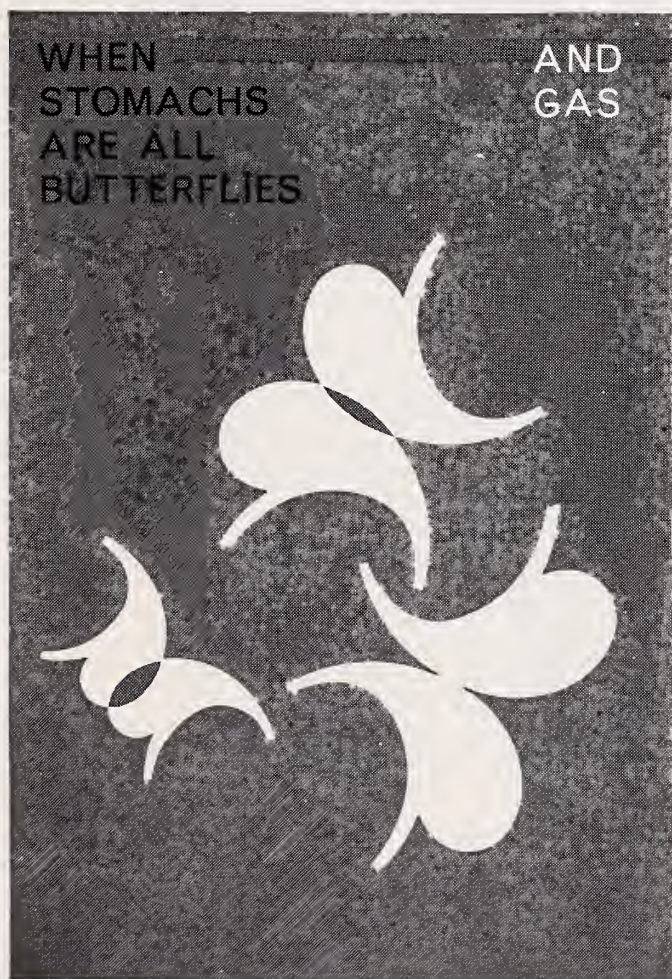
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100 mg.; Taurocholic acid, 15 mg.

\*Need in human nutrition not established.

\*\*As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

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**Administration and Dosage:** One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

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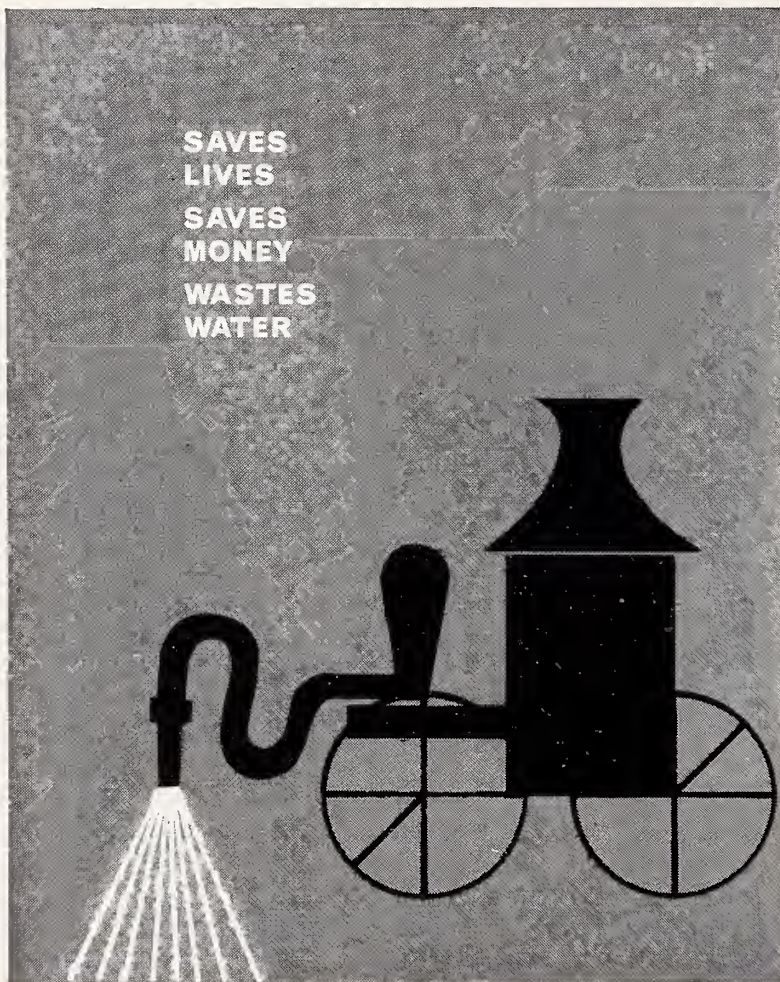
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METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*

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**Dosage:** One 2 or 4 mg. tablet once or twice daily.

**Precautions:** As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

**Side Effects:** Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

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**How Supplied:** Bottles of 100 and 1000 tablets.

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**NORPRAMIN<sup>®</sup>**

(desipramine hydrochloride)

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Norpramin (desipramine hydrochloride) reverses the signs and symptoms of depression including sleep disturbances, feeling of sadness, guilt, worthlessness, anxiety and bodily complaints without physical basis. In 2-5 days most patients become more hopeful, more active and less weighed down by their problems.

Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

**Indications:** In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

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## **CANTIL<sup>®</sup>** (mepenzolate bromide)

### helps restore normal motility and tone

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function... Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects... Urinary retention, noted in two cases was eliminated in one by reducing dosage."<sup>1</sup>

**IN BRIEF:** One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withdraw in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

**Supplied:** CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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In fact, there's as much iron...250 mg.  
...in a 5 cc. ampul of Imferon (iron dextran  
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When iron deficient patients are intolerant  
of oral iron...or orally administered iron  
proves ineffective or impractical...or if  
the patient cannot be relied upon to take oral  
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and rapidly replenishes iron reserves.

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**IN BRIEF: ACTION AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

**COMPOSITION:** Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

**ADMINISTRATION AND DOSAGE:** Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

**SIDE EFFECTS:** Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

**PRECAUTIONS:** If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

**CONTRAINDICATIONS:** Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

**CARCINOGENICITY POTENTIAL:** Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

**SUPPLIED:** 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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## PRESIDENT'S LETTER

### In Retrospect

THE 112TH ANNUAL SESSION in Columbus was enjoyed by all who attended. Our Columbus colleagues, the Ladies Auxiliary and all others who contributed so much and worked long hours to make the meeting successful, both socially and professionally, are due a vote of thanks from all of us who were so graciously entertained and cared for. The scientific programs were of very high quality and many timely and pertinent papers were presented.

#### Attendance

Again we note with concern the decreased attendance. There were 510 members present from the total MAG membership of 3,350. Attendance for the previous five years:

1965	622 of 3,260
1964	579 of 3,170
1963	642 of 3,075
1962	686 of 3,025
1961	876 of 2,930

The delegate attendance was and has been very gratifying. There were 111 of 157 attending. Attendance for the previous five years:

1965	113 of 156
1964	103 of 149
1963	111 of 149
1962	101 of 144
1961	102 of 144

Our legislative committee held the annual meeting of MAG and our congressional delegation in Washington on May 25-26. All of our congressmen and

Senator Richard Russell were present. It was a harmonious and productive meeting. Impending legislation in which we are interested was discussed here and with our AMA office.

One member of MAG from each district; Frank Walker, our legislative committee chairman, and Jim Moffett were present, also, two representatives from our Washington office. Others attending were: myself, Edwin Griffin, Bainbridge; Frank Wilson, Leslie; Luther M. Vinton, Jr., Decatur; James M. Kaufmann, Atlanta; T. A. Sappington, Thomaston; Donald R. Rooney, Marietta; James M. Hicks, Brunswick; Charles R. Andrews, Jr., Canton; and Harry D. Pinson, Augusta.

When this article appears in our *Journal*, Medicare will have become law and be in active operation. I will not belabor our concerns and apprehensions further at this time. We can only wait and see what problems develop and approach each one as is timely. We were told in Washington that already there are 26 proposed amendments to the law, all of which are for expanding the benefits as presently enumerated. It is expected by our Washington (AMA) office that there will yet be many more offered after the law becomes operative. I am sure we are in agreement that none of us at this time can estimate the impact on the operation of our offices, on added requests, and needs for hospital admissions and nursing home facilities. One day of the coming AMA convention in Chicago will be devoted to all these problems and to impending new developments.

Walter E. Brown, M.D.

President, Medical Association of Georgia





### RUPTURED ABDOMINAL AORTIC ANEURYSMS

Milton F. Bryant, M.D., *Atlanta*

UNQUESTIONABLY, RUPTURED aneurysms of the abdominal aorta are associated with a high mortality rate. Reported mortality rates vary from 25% to 80%. Elective resection of abdominal aortic aneurysms is associated with a mortality rate of 5% to 10%. These figures provide a strong argument in favor of elective resection of all symptomatic arteriosclerotic abdominal aneurysms and all asymptomatic aneurysms greater than 5 to 7 cm. in diameter—provided the patient's general condition allows the performance of a major surgical procedure.

The initial symptoms associated with ruptured aneurysms are usually severe abdominal pain radiating to the back, or sudden severe low back pain frequently accompanied by nausea and vomiting. At times the pain may be located in the flank region and may radiate to the groin so as to simulate acute renal colic. Close questioning will often reveal the fact that the patient has noted a "jumping" or "bumping" sensation in his abdomen for varying periods of time. Others "feel as if their heart has fallen into their abdomen."

#### Clinical Diagnosis

The clinical diagnosis is usually not difficult, as the above symptoms associated with moderate or profound shock and a large tender pulsating abdominal mass is pathognomonic of a ruptured aortic aneurysm. At times shock may be mild and a mass is not palpable. In these instances lateral x-ray films of the lumbar spine and an intravenous pyelogram may be helpful in establishing the diagnosis. Calcification outlining the walls of the aneurysm, obliteration of one or both psoas shadows, along with displacement of the ureters, is noted with ruptured aneurysms.

After the diagnosis is established, cutdowns with

intravenous catheters are placed in the arms. One catheter should extend to the level of the superior vena cava so that the central venous pressure can be monitored. A catheter should be inserted into the urinary bladder. The patient is taken to the operating room and dextran or an albumin solution is given while appropriate quantities of blood are obtained. No attempt is made to replace the blood volume before surgery is begun. A long mid-line incision is made and a vascular clamp is quickly placed across the abdominal aorta just distal to the renal arteries, or at times across the aorta above the renal arteries. One can now effectively restore the blood volume. Monitoring of the central venous pressure is essential in order to help guide volume replacement and prevent cardiac overloading. An intravenous drip of 20% Mannitol is started to help prevent oliguria and anuria. It is important to keep the dissection to a minimum and to this end portions of the posterior and lateral walls of the aneurysm are usually left attached to the vena cava and the lumbar spine. A Y-shaped knitted dacron or teflon graft is sutured to the cuff of the aorta distal to the renal arteries and then to the iliac or common femoral arteries.

Continuous measurement of the central venous pressure should be carried out postoperatively. The cardiac status must be carefully watched and an hourly urine output of 30-60 cc should indicate adequate perfusion of the kidneys. The routine use of a gastrostomy and the mechanical ventilator has helped prevent postoperative pulmonary complications.

*Sheffield Building  
1938 Peachtree Rd., N.W.*

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*Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.*



## REPORTING OF CHILD ABUSE

John L. Moore, Jr., *Atlanta*

SEVERAL REQUESTS have been received by the *Journal* for a discussion of the new statute entitled "Reports of Cruel Treatment of Children" enacted into law at the 1965 Session of the General Assembly of Georgia. The statute has been codified as § 74-111 of the Code of Georgia of 1933.

### Reports Required

Any physician, licensed osteopathic physician, intern, resident, public health nurse or welfare worker having cause to believe that a child under the age of twelve brought to him or coming before him for examination, care, or treatment has had physical injury or injuries inflicted upon him other than by accidental means by a parent or caretaker must make reports as provided in the statute. The complex sentence above paraphrased can be broken down as follows. A report must be filed by one of the named persons:

1. if he has cause to believe that a child;
2. the child being under the age of twelve;
3. being examined either brought to the person or coming before him for examination, care, or treatment;
4. has had physical injury inflicted upon him other than by accidental means;
5. by a parent or caretaker.

If the physician sees the child on the street and does not undertake to examine him or provide him care or treatment, the physician would not be required to make a report and would not be protected if he made the report even if all of the other conditions are satisfied. Further, if the physician has cause to believe that the injuries were inflicted on the child by any person who was not the child's parent or caretaker, no report is required and no protection would be given the physician if he made a report even if all the other prerequisites were satisfied.

Similarly, if the child is over twelve years of age,

no report is required and the physician would not be protected from liability if he made a report.

### To Whom Report Is Made

If the physician or other person sees the child "pursuant to the performance of services as a member of the staff of a hospital or similar institution," his obligation is simply to notify the person in charge of the institution or his designated delegate who makes further reports. If the person seeing the child is a public health nurse or welfare worker, the report is made to the county health officer or if there is none in the county, to any licensed physician who is then required to make an examination of the child and if he concurs that the injuries were inflicted as stated in the statute, the duty to report is then placed upon the physician.

The statute requires that all reports be made by the person responsible immediately by telephone or otherwise to "a child welfare agency providing protective services, or in the absence of such agency, to an appropriate police authority." The oral report must be followed by a report in writing containing the names and addresses of the child and his parents or caretakers, if known, the child's age, the nature and extent of the child's injuries including any evidence of previous injuries, and any other information that the reporting person believes may be helpful in establishing the cause of the injuries and the identity of the perpetrator.

### Immunity From Liability

Any person or entity participating in the making of reports pursuant to the statute is relieved of any liability, civil or criminal, that might otherwise be incurred or imposed "providing such participation pursuant to this section or any other law shall be made in good faith." It should be understood that this is immunity from liability and not from filing suit. A parent may still sue a physician who made



such a report claiming that the report was made otherwise than in good faith. This, of course, is a question of fact to be decided by the jury.

The meaning of "good faith" is obvious. However, factual proof of "good faith" often is difficult. The physician making a report should document the facts upon which he relies as carefully as possible in his file. His file should contain the usual history and reports of other experts, if any. For example, if a broken bone is suspected it is strongly urged that the physician have an x-ray upon which to base his belief that a bone was broken. If the child shows external evidence of injury or mistreatment, it is suggested that the physician also have other members of his staff who saw the child write memoranda describing exactly what they saw. Such memoranda should be signed by the persons making them and kept by the physician who made the report. Such memoranda can be very important in protecting a physician if the person making a memorandum is no longer employed by the physician or may have forgotten the particular instance. Of course, a copy of the report to the child welfare agency or to the police should be kept in the physician's file as well as a memorandum dictated by the physician immediately after the oral report stating his current recollection of exactly what was said in making the oral report.

### Purpose of the Statute

The statute itself provides that the purpose of the statute is to provide for the protection of children whose health and welfare are adversely affected and further threatened by the conduct of those responsible for their care and protection.

It is interesting to state that in the years 1963 through 1965, 45 of the 50 States passed laws re-

quiring reporting of abuses of children. Apparently only Hawaii, Idaho, Kentucky, Mississippi, and Virginia have not passed such a statute although one or more of those States may have passed such a statute since January, 1966.

It seems to the writer that the objectives of the child abuse statute are obvious and sensible. There have been similar statutes requiring the reporting of injury to animals for a long time. However, objections to mandatory reporting of child abuse have been raised. One objection is that the statute concentrates on the abused child with insufficient regard for the welfare of siblings. Further, it is sometimes stated that the mandatory reporting requirements could increase the hazards for the abused child in either of two different ways. The parent or caretaker of the child may not seek medical care for a child needing it because of fear of criminal involvement. The immediate involvement of the police is sometimes considered to cast a premature criminal aura on adult caretakers who may be guiltless. A final criticism states that the social nature of the crises leading to child abuse suggests the use of a social rather than a legal agency to receive reports of abuse of children. The Georgia statute recognizes this criticism and calls for reports to a child welfare agency providing protective services, if any.

Perhaps the widespread enactment of mandatory reporting laws will lead to a broadening of community services to the entire family involved in an instance of child abuse. If so, some of the other important objections to the statute would be solved.

*Suite 1220  
C & S Bank Building*

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*Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to the Medical Association of Georgia.*

## DOCTORS ENTERTAIN GEORGIA CONGRESSIONAL DELEGATION IN WASHINGTON

For the eighth consecutive year Georgia doctors entertained members of the Georgia delegation in the Congress at an informal luncheon in the nation's Capitol.

On May 26, eleven physicians representing all parts of the state honored Georgia's House and Senate delegations with a luncheon described by Senator Russell as an event rapidly becoming one of Washington's more pleasant institutions. The luncheon was arranged through the good offices of Congressman Robert G. Stephens, Jr. of Athens and the Tenth Congressional District. It was given in the private dining room of the Speaker of the House and was attended by each of the ten House Members and Senator Russell. Senator Talmadge was unexpectedly called away at the last moment and was unable to attend. He was represented by a member of his staff.

As in the past the MAG group flew to Washington in the evening preceding the day of the luncheon. Following briefing sessions that night and again the following morning by the AMA Washington Office, members of the MAG delegation called individually on their respective Congressman for a frank discussion of legislative matters pending in the Congress.

The luncheon, sponsored by the MAG Legislative Committee, was designed to improve rapport between members of the medical profession and our Washington representatives. By unanimous agreement of all those who attended, it was a successful undertaking and one that will improve understanding between doctor and lawmaker in the future.



## GEORGIA PSYCHIATRY

Julius T. Johnson, M.D., *Augusta*

(Excerpt from Dr. Julius T. Johnson's letter to the Georgia Psychiatric Association as Incoming President of the Georgia Psychiatric Association.)

SEVERAL YEARS ago there was a hue and cry to get "Psychiatry back into the mainstream of Medicine!" Then more recently as the "High Society" (high cost, high taxes, high dependency on the Federal Government, high (?) ideals) started getting into swift forward progress, it seems that Medicine and specifically Psychiatry seemed to be an opportune football to use. Then followed, "if you do not plan for yourself, someone will plan for you." Our system of medical care—the best system of medicine in the world—may well have been dealt a crippling blow by the passage of "Fedicare." In Psychiatry the "ideal frontier" seems to be to invest tremendous sums of money (hopefully Federal) in a new venture—Comprehensive Community Mental Health Centers. In this day of rapid change, let us hope we will make every effort to be involved in planning the future so that we are active participants rather than "Monday morning quarterbacks." Let us not be reactionary to various components of our teams—i.e. the State Board of Health, MAG, etc.—who thus far have, in my opinion, reacted wisely and with dignity to further our already great system of Medicine. Let us hope there are not those among us who become so deafened by the roar of federal dollars, over-determined ideals, and the sweeping tide of socialism

that they cannot hear the signals and may ruin the play for their team, the spectators and the tremendous T.V. audiences. Let us hope we will move with dignity and unity to pass on to our heirs a better game than when we began and especially not pass on a monstrosity that will ruin the game for the future.

*Addendum:*

### The Growth of the Georgia Psychiatric Association

The forerunner of the GPA was a committee named "Committee of Psychiatrists for the Georgia Mental Health Association." In July, 1954, this committee named a Constitution Committee and in September, 1954 a formal petition signed by 31 members was submitted to the American Psychiatric Association. Approval from the American Psychiatric Association was obtained and in May, 1955 the first organizational meeting of "The Georgia Psychiatric Association, a District Branch of the American Psychiatric Association," was held in Atlanta, Georgia, with 34 charter members. The GPA has grown rapidly and now has some 120 members, from eleven different cities. There are five approved residency programs in the state with approximately 50 residents in Psychiatry. This reflects, I think, the rapid growth of Georgia Psychiatry.

*1445 Harper Street*

*Prepared at the request of the Sub-Committee on Mental Health of the Medical Association of Georgia.*

## NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Brice, Anton, Jr.  
Active—DeKalb

Chambers, Roy G.  
Active—Richmond

Jarrell, John A., Jr.  
Active—Fulton

Jones, Kenneth D.  
Active—Baldwin

542 Church Street  
Decatur, Georgia 30030

1423 Harper Street  
Augusta, Georgia 30902

1938 Peachtree Street, N.W.  
Atlanta, Georgia 30309

Milledgeville State Hospital  
Milledgeville, Georgia 31602

Lang, W. Steve  
Active—Glynn

Lindquist, Harley D.  
Active—Crawford W. Long

Perez, A. R.  
Active—Fulton

Sapp, William P., Sr.  
Active—Baldwin

3011 Kemble Avenue  
Brunswick, Georgia 31520

St. Mary's Hospital  
Athens, Georgia 30601

490 Peachtree Street, N.E.  
Atlanta, Georgia 30308

Milledgeville State Hospital  
Milledgeville, Georgia 31602





# THE ASSOCIATION

## DEATHS

**DeWitt T. Bond**, 57, of Danielsville, died suddenly at his home April 24, 1966.

Dr. Bond was a prominent Madison County physician, and had practiced medicine for many years. He was a veteran of World War II and a member of Danielsville Civitan Club, the Masons, and the Danielsville Methodist Church.

Survivors include his widow, Mrs. Elise Quattlebaum Bond, of Danielsville; a daughter, Mrs. John H. Wood, of Danielsville; a son, Pete Bond of Ila; a sister, Mrs. C. J. Tyner of Danielsville; three brothers, Fred Bond, of Andalusia, Alabama; Leo L. Bond of Danielsville and Joseph Roy Bond, of LaGrange; four grandchildren.

**Shelley Carter Davis**, Atlanta surgeon who was the founder of the Atlanta Clinical Society, died May 22, 1966.

Dr. Davis, a practicing surgeon for more than 38 years, was the son of the late Dr. Edward Campbell Davis, founder of Crawford W. Long Hospital.

Before entering private practice, Dr. Davis trained at Lakeside Hospital in Cleveland, Ohio; Lying-In Hospital and Memorial Cancer Hospital in New York, and the American Hospital in Paris, France. He also trained in clinics in Vienna, Austria and Heidelberg, Germany.

He was an active member of the Fulton County Medical Society, Medical Association of Georgia, the American Medical Association, the American College of Surgeons, the International College of Surgeons, the Southeastern Surgical Congress, the Alpha Kappa Medical Fraternity and several honorary medical fraternities.

He was a member of the Second Ponce de Leon Baptist Church, the Capital City Club, the Atlanta Athletic Club, and the Kiwanis Club.

Survivors include his wife, the former Ethel York; a daughter, Mrs. W. G. Sewell, Bremen; a son, Dr. S. Carter Davis, Jr., Thailand; mother, Mrs. E. C. Davis, Sr.; five sisters, Mrs. Earl McMillen, Mrs. Bradford McFadden and Mrs. John B. Warner, all of Atlanta, Mrs. Fred S. Marks, Rome, New York, and Mrs. E. Storm Trosdal, Savannah; two brothers, Dr. Robert Carter Davis and Lt. Col. E. C. Davis, Jr., U.S. Army (ret), both Atlanta.

**George R. Gish, Jr.**, Atlanta neurosurgeon, died May 7, 1966, in a local hospital. He was 48.

A native of Bluefield, West Virginia, Dr. Gish studied at Davidson College and the Medical College of Virginia in Richmond. His residences in neurosurgery were supervised by Dr. C. C. Coleman in Richmond, and later, at Emory University Hospital, by Dr. Edgar Fincher.

Dr. Gish was awarded a Bronze Star during World War II while a medical captain in the European Theater.

Dr. Gish moved to Atlanta in 1951. He was a staff member of Georgia Baptist Hospital and the Emory

University Hospital, and a member of the Fulton County Medical Society, the American Medical Association and the Weiucu Baptist Church.

Surviving are the widow, the former Anne Murray, a daughter, Margaret Ellen Gish of Atlanta; three sons, Bobby, Tommy and Stevie Gish of Atlanta; and father, George R. Gish, Sr., of Bluefield, West Virginia.

**Leon J. Goodman** of Macon died in a local hospital April 30, 1966.

Dr. Goodman was born in Milwaukee, Wisconsin and had resided in Macon for 20 years.

Dr. Goodman was a member of the Temple Beth Israel, Elks Club, Masons, Bibb County Medical Society, Medical Association of Georgia, American Medical Association, Fellow American College of Surgeons, International College of Surgeons, Macon Obstetrical Society and the State Obstetrical and Gynecology Society.

Surviving are his widow, the former Miss Hortense Aronson, Macon, one son, Judd Goodman of Macon; one brother, Sidney Goodman of Detroit, Michigan; and one sister, Mrs. Theresa Finston of Detroit.

## COUNTY MEDICAL SOCIETIES

**Thomas-Brooks County Medical Society** held its quarterly meeting June 16, 1966, at Archbold Memorial Hospital, Thomasville, Georgia. The program was devoted to the new Medicare law. Topics were, "The Role of the Carrier, Part A, P.L. 89-97"; "The Role of the Carrier, Part B, P.L. 89-97," Maurice F. Stevenson, Administrator, John Hancock; "The Role of the Social Security Administration under P.L. 89-97," and a panel discussion which included the guest speakers and Mr. Patrick Fenlon, Administrator, The John D. Archbold Memorial Hospital.

## PERSONALS

Among Georgia physicians recently honored as Fellows at the 47th Annual Session of the American College of Physicians were **David E. Hein**, **J. Spalding Schroder**, and **Grattan C. Woodson, Jr.**, all of Atlanta; **Alex Murphey**, Augusta; **William P. Roche, Jr.**, Dublin; and **Sergio C. Alvarez-Mena**, Milledgeville.

### First District

**Gerald B. Hogsette** attended a postgraduate course in trauma conducted by the Chicago Committee on Trauma in Chicago, April 20-23, 1966.

### Third District

**Col. Daniel E. Nathan**, Robins Air Force Base, was among key Air Force Reserve officers attending the recent 37th Annual Aerospace Medical Association meeting in Las Vegas, Nevada.



## THE ASSOCIATION / Continued

### Fourth District

**Thomas J. Busey, Jr.**, of Fayetteville was among the 20 surviving members of Emory University's 1916 medical class who gathered recently at the Marriott Motor Hotel in Atlanta. It was the first class get-together in 50 years. Of the original 120 graduates, 26 are still living. The 20 men attending the event are still practicing medicine.

A panel of prominent physicians participated in a public forum on, "Heart Attack," April 21, 1966, in Thomaston. **Herbert Tyler**, Thomaston, moderated the panel. Panel members included three other specialists in internal medicine: **Ira H. Slade**, Griffin; **J. W. Smith**, Manchester; and **Ernest Proctor**, Newnan.

### Fifth District

**Elton S. Osborne, Jr.**, a native Georgian, has recently been appointed the new Deputy Director of the Georgia Department of Public Health. Born in Savannah, Dr. Osborne was serving as Deputy State Health Officer for the Florida State Board of Health prior to his present appointment.

**Carter Smith**, Atlanta, attended the AMA Convention in Chicago and represented the Section on Internal Medicine in the House of Delegates. Following the AMA Convention, Dr. Smith, a Trustee of the American Society of Internal Medicine, attended the meeting of its Board of Trustees. He has recently been elected to the Board of Regents of the American College of Physicians.

**James F. Schwartz**, Emory University School of Medicine, Atlanta, addressed a meeting sponsored by the Greater Atlanta Chapter of the Epilepsy Foundation in May. His topic concerned epileptic seizures.

**Robert M. Fine**, Decatur, attended the meeting of the Arkansas Dermatological Society April 30 in Little Rock, Arkansas, and the Georgia Dermatological Association meeting in Columbus, Ga., May 7 and 8. He also attended the Southeastern Dermatological Association meeting in Louisville, Kentucky, May 20-22.

**Bernard S. Lipman**, Atlanta, was a guest lecturer May 19-20, 1966, at the Annual Scientific Sessions of the Tennessee Heart Association, Gatlinberg, Tennessee. The meeting was sponsored by the Tennessee Heart Association in cooperation with the Tennessee Department of Public Health Heart Disease Control Program and the University of Tennessee College of Medicine.

**Alfred A. Messer**, Atlanta, presented a paper entitled "Successful Family Treatment of a Patient Who Failed in Psychoanalysis," at the 122nd Annual Meeting of the American Psychiatric Association in Atlantic City, New Jersey, in May, 1966.

**Tully T. Blalock**, Atlanta, has been elected the Georgia representative of the American College of Physicians. Dr. Blalock was elected to the post, with the title of Governor, at the 47th Annual Session of the ACP.

Two Atlanta physicians recently visited Athens for an interview regarding progress in cancer research. **John P. Wilson**, practicing surgeon and advisor to the Fulton County Cancer Society, and **John T. Galambos**, Emory University School of Medicine, were interviewed by Mrs. Sterling Wilhoit of Athens. The program was aired April 19, 1966, after being taped.

**William A. Hopkins**, thoracic surgeon, and **Elbert P. Tuttle**, Emory University research scientist, were two of the Atlanta participants at the 18th Annual Meeting of the Georgia Heart Association in Atlanta April 21, 1966. They discussed, "The Fruits of Research," covering recent progress in heart research.

### Eighth District

**Charles G. Green** of Waynesboro has been elected President of the Alumni Association of the Medical College of Georgia.

Valdosta physician, **David Branch**, spoke recently to the Georgia Christian School Parent-Teacher Association. Dr. Branch's topic was entitled, "Your Child's Health."

### Ninth District

The Directors of the American Board of Obstetrics and Gynecology have announced the certification of **Elton L. Copelan** as a Diplomate of the American Board of Obstetrics and Gynecology. Dr. Copelan is associated in group practice as a partner of The Toccoa Clinic Medical Associates, Toccoa, Georgia.

### Tenth District

**John L. Bowen**, formerly of Atlanta, has joined the staff of the Medical College of Georgia as Assistant Professor of Pediatrics.

Nine faculty members and a student from the Medical College of Georgia, Augusta, participated in the 15th Anniversary Clinical Meeting of the American College of Obstetricians and Gynecologists April 30-May 5, 1966, in Chicago. Participants from the Dept. of OB-GYN were **Frederick P. Zuspan**, **P. Lea Wilds**, **Eduardo Talledo**, **George H. Nelson**, and **Chester B. Martin**. Participants from the Dept. of Endocrinology were **Robert Greenblatt**, **J. R. Byrd**, **Virenda B. Mahesh**, and **Paul McDonough**. An exhibit, "Gonadal Dysgenesis," was presented by the Dept. of Endocrinology.

A Medical College of Georgia professor has received a \$2,500 unrestricted grant from Wyeth Laboratories. The presentation to **Victor Moore**, Associate Professor in the Department of Medicine, was made at a luncheon at the Augusta Town House, Augusta, Georgia.

## NO ONE KNOWS LIKE THE MAKER

When physicians encounter an adverse drug reaction it is not uncommon for them to write to the distributor of the drug, possibly in the form of a complaint or as a request for information on similar experience. Re-

ports are often transmitted through the detail man. No one knows as much about marketing experience with a drug as its distributor.—**Ralph G. Smith, M.D.**, in *Journal of New Drugs* (6:66), Jan.-Feb., 1966.



# COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA

## 1966-67

### OFFICERS

- \*President—Walter E. Brown, Savannah (1967)
- \*President-Elect—John T. Mauldin, Atlanta (1967)
- \*Immediate Past President—George H. Alexander, Forsyth (1969)
- Past President—J. G. McDaniel, Atlanta (1968)
- Past President—George R. Dillinger, Dublin (1967)
- \*First Vice President—Lamar B. Peacock, Atlanta (1967)
- \*Second Vice President—M. C. Adair, Washington (1967)
- \*Chairman of Council—Charles R. Andrews, Jr., Canton (1967)
- \*Secretary—J. Rhodes Haverty, Atlanta (1969)
- \*Treasurer—John S. Atwater, Atlanta (1967)
- \*Speaker of the House—J. Frank Walker, Atlanta (1968)
- Vice Speaker of the House—Harrison L. Rogers, Jr., Atlanta (1968)
- Editor JMAG—Edgar Woody, Jr., Atlanta (1967)

### COUNCILORS

#### District:

- 1—C. E. Bohler, Brooklet (1967)
- 2—J. D. Bateman, Albany (1967)
- 3—Frank A. Wilson, Leslie (1967)
- 6—Charles T. Cowart, LaGrange (1968)
- 7—Ralph N. Johnson, Rome (1968)
- \*8—F. G. Eldridge, Valdosta (1968)
- 9—C. R. Andrews, Jr., Canton (1969)
- 10—Addison W. Simpson, Washington (1969)

Bibb County Medical Society  
Braswell E. Collins, Macon (1969)

Cobb County Medical Society  
W. C. Mitchell, Smyrna (1969)

DeKalb County Medical Society  
Floyd R. Sanders, Decatur (1969)

Fulton County Medical Society  
Linton H. Bishop, Atlanta (1968)  
J. Harold Harrison, Atlanta (1967)  
Fleming L. Jolley, Atlanta (1969)

Georgia Medical Society Councilor  
T. A. Peterson, Savannah (1967)

Muscogee County Medical Society  
Luther H. Wolff, Columbus (1968)

Richmond County Medical Society  
Harry D. Pinson, Augusta (1969)

\* Executive Committee

### VICE COUNCILORS

#### District:

- L. H. Griffin, Claxton (1967)
- Homer L. Lassiter, Arlington (1967)
- J. T. Christmas, Vienna (1967)
- J. M. Kellum, Thomaston (1968)
- David A. Wells, Dalton (1968)
- J. W. Yeomans, Jesup (1968)
- P. T. Scoggins, Commerce (1969)
- William Rawlings, Saundersville (1969)

W. H. M. Weaver, Macon (1969)

Murl M. Hagood, Marietta (1969)

M. Freeman Simmons, Decatur (1969)

J. Norman Berry, Sandy Springs (1968)  
Frank L. Wilson, Jr., Atlanta (1967)  
T. J. Anderson, Jr., Atlanta (1969)

John Kirk Train, Savannah (1967)

Roy L. Gibson, Columbus (1968)

J. L. Mulherin, Augusta (1969)

### DELEGATES TO AMA

Delegate	Term Ending	Alternate Delegate	Term Ending
J. W. Chambers, LaGrange	12-31-67	T. A. Sappington, Thomaston	12-31-66
J. Frank Walker, Atlanta	12-31-66	John Kirk Train, Savannah	12-31-66
Preston D. Ellington, Augusta	12-31-66	John T. Mauldin, Atlanta	12-31-66
Henry H. Tift, Macon	12-31-66	John S. Atwater, Atlanta	12-31-66

### DELEGATES TO AMA AS OF JANUARY 1, 1967

Delegate	Term Ending	Alternate Delegate	Term Ending
J. W. Chambers, LaGrange	12-31-67	Neal F. Yeomans, Waycross	12-31-67
John S. Atwater, Atlanta	12-31-67	Henry S. Jennings, Gainesville	12-31-67
J. Frank Walker, Atlanta	12-31-68	John Kirk Train, Savannah	12-31-68
Preston D. Ellington, Augusta	12-31-68	F. W. Dowda, Atlanta	12-31-68

## APPLICATIONS FOR RESEARCH SUPPORT IN 1967 NOW AVAILABLE FROM AMERICAN HEART ASSOCIATION

Applications from research investigators for support of studies to be conducted during the fiscal year beginning July 1, 1967, are now being accepted by the American Heart Association.

*Established Investigatorships*, which are five-year awards, carry a stipend of \$11,000 with increments of \$1,000 yearly and fringe benefits, and are made to scientists of proven independent research capabilities.

*Advanced Research Fellowships* are available to post-doctoral applicants who have a minimum of two years research experience at the time of application, but who are not clearly qualified to conduct independent research. This one-to-two year award carries a stipend of \$6,500 plus dependency allowance and yearly increments.

*Career Investigators* are appointed by the American Heart Association's Board of Directors on recommendation of the national Research Committee and not by application. These awards are limited in number to investigators of unusual capacity and widely recognized accomplishment, and assure financial support throughout their careers.

*Grants-in-Aid* carry an application deadline of November 1, 1966. Grants-in-Aid are made to experienced investigators to help underwrite the costs of specified projects, such as equipment, technical assistance and supplies.

Application forms for research awards may be obtained from the *Director of Research, American Heart Association, 44 East 23rd Street, New York, New York 10010*.

### GEORGIA DEPARTMENT OF PUBLIC HEALTH ALCOHOLIC REHABILITATION SERVICE TO PRESENT ONE-WEEK TRAINING PROGRAM

The Georgian Clinic is happy to announce the continuation of the one-week training program entitled, "Introduction to the Attitudes and Techniques Useful in Rehabilitation of the Chronic Alcoholic."

#### *Course offerings:*

First Offering: September 12, 1966, through December 16, 1966 (excluding week of November 21-25 for Thanksgiving)

Second Offering: January 2, 1967, through March 31, 1967

Third Offering: April 17, 1967, through June 9, 1967.

The courses will be offered weekly, Monday mornings through Friday afternoons. Housing is available and trainees are expected to live on or near the Clinic grounds.

#### **General Information**

The course is conducted at the Georgian Clinic. The Clinic offers a resident patient-care program as well as a day patient program for individuals addicted to alcohol. The program is designed as an orientation for the professional worker and includes basic information which can be used by him when he returns to his job. Evaluating tools and tests are utilized during the week's experience to increase the effectiveness of the program. The tests are taken by the trainees on a strictly voluntary basis.

#### **Facilities**

The facilities include a 50-bed resident patient department together with a day patient clinic. The treatment program consists of complete evaluation of the patient, including complete medical, laboratory, psychiatric, psychological, social work, sociological and vocational work-ups; medical management of the withdrawal symptoms; long-range psychopharmacological treatment;

group psychotherapy and group education; individual counseling; occupational, recreational, and music therapy; and group therapy for the patient's family in a therapeutic milieu.

The method of teaching utilized is a combination of didactic instruction, small group discussion, audio-visual aids, observation of treatment attitudes and techniques with a large group of patients in the Georgian Clinic.

#### **Instructional Staff**

The Clinic is staffed by a highly trained staff consisting of physicians, psychiatrists, pastoral counselors, psychologists, social workers, nurses, training coordinator, occupational therapist, vocational rehabilitation counselor, and ancillary personnel.

#### **Enrollment Information for Prospective Participants**

*For whom:* Professional workers such as physicians, nurses, social workers, psychologists, vocational rehabilitation counselors, sociologists, and health educators.

*Fees and Expenses:* Tuition for the course is \$177.40. Room and board at the Clinic for the week is \$40.00. Scholarships for tuition and/or stipends for room and board are available for professionals with the exception of federal employees. Participants or their sponsoring agency must provide all costs of travel incurred in attending these courses.

*Application:* Those desiring to attend these courses should apply as soon as possible. Applications will be considered in the order received and applicants will be notified promptly of the action taken.

To apply for training or for further information, please call or write: *Mrs. Patricia Donaldson, Coordinator of Training, 1260 Briarcliff Road, N. E., Atlanta, Georgia 30306, 873-5341, Ext. 46*



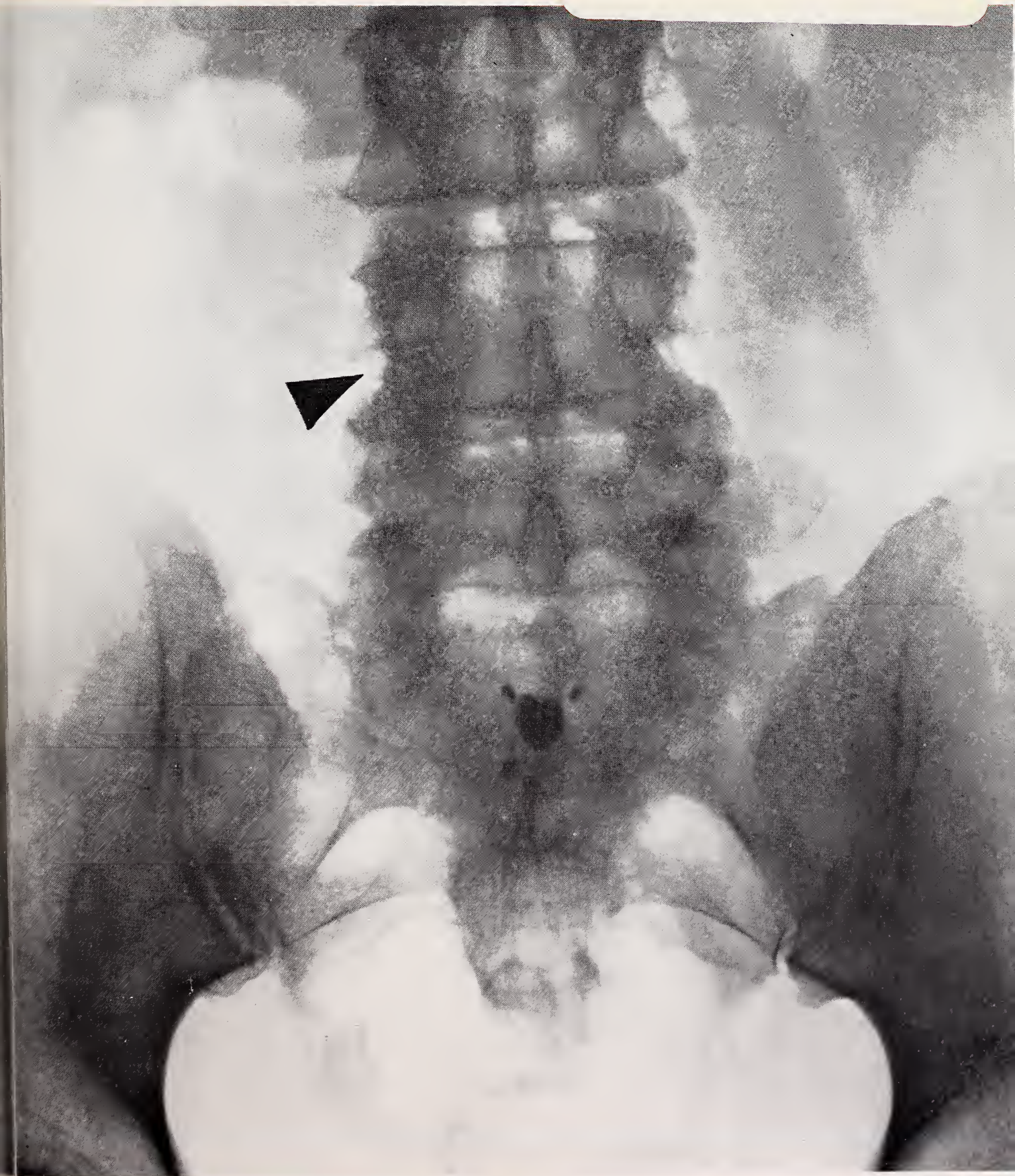
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# LUMBAR FACET FRACTURES FOLLOWING DISK SURGERY

Fred P. Sage, M.D., *Memphis, Tennessee*

■ This complication has not been reported previously in the literature.

**R**ECURRENT LOW BACK pain following lumbar disk surgery is often perplexing to the patient and his physician. Where this occurs following multiple disk operations, it is distressing.

## The Cause

During the past two years we have found a fracture of a lumbar facet in six patients who have had one or more lumbar disk operations. These always occurred on the operated side. These fractures were felt to be the cause of recurrent low back pain in these patients.

To my knowledge, this complication following disk surgery has not been reported. It is my purpose to present a résumé of these cases, such that this complication is brought to the attention of physicians who treat patients for low back pain.

## Case Reports

*Case No. 1.* A 20-year-old male was readmitted to Baptist Memorial Hospital in Memphis, Tennessee, on November 8, 1964, with a history of low back pain for two years. Eleven months prior to this admission, he had had a herniated nucleus pulposus removed from the 4th lumbar interspace on the right by a subtotal hemilaminectomy of the 3rd, 4th, and 5th lumbar vertebrae. On the fourth day following this surgery, while turning in bed, he felt something pop in his back. He had immediate spasms in his back, which were initiated by movement and relieved by rest. This discomfort persisted daily for 11 months in spite of prolonged hospitalization and numerous conservative measures.

On the November, 1964 readmission, roentgenograms of his low back and a lumbar myelogram were felt to show a rotary subluxation of the 4th

right lumbar inferior facet on the 5th right lumbar superior facet. Exploration of this area and fusion of the 3rd lumbar vertebra to the sacrum was advised. On November 18, 1964, his low back was re-explored and an ununited fracture of the right inferior facet of the 4th lumbar vertebra was found. In reviewing the roentgenograms retrospectively, this facet fracture was discernible in the antero-posterior view as well as on the oblique view of this area taken during the lumbar myelogram. (Figure 1.)

The facet fragment was excised and a fusion was performed extending from the 3rd lumbar vertebra to the sacrum. His course following surgery was uneventful and he was returned to work seven months following his fusion. (Figure 2.)

*Case No. 2.* A 31-year-old female was readmitted to the Baptist Hospital on March 3, 1965, with a history of two previous low lumbar explorations and removal of herniated disk material from the left side at the 4th and 5th lumbar interspaces. The last exploration was five months prior to this admission, and the patient was relieved of low back and left leg pain which she had had prior to the operation. She had then developed bilateral sacro-iliac pain two months later and had a typical roentgenogram of osteitis condensans ilii. (Figure 3.) Phenylbutazone had relieved this discomfort dramatically. She was then free of pain for approximately two months. Three weeks prior to this admission, she suddenly sneezed, while sitting at a table, and immediately had recurrent low back and left leg discomfort. A progressive hypesthesia of the inner aspect of the left foot occurred, accompanied by extreme muscle spasms in her back.

It was believed that she had sustained a recurrent disk herniation and a myelogram was done. A spondylolysis of the 5th lumbar vertebra was reportedly seen on the oblique projection of the myelogram.

From the University of Tennessee Medical School, and the Campbell Foundation, Memphis.

Presented at the 112th Annual Session of the Medical Association of Georgia, May 8, 1966, Columbus, Georgia.





FIGURE 1

Case No. 1.—AP roentgenogram and oblique myelogram roentgenograms showing fracture of right inferior facet of the 4th lumbar vertebra.

This was puzzling, for the patient had previously had numerous low back roentgenograms from all projections made, and no trace of spondylolysis had ever been found. On March 24, 1965, in conjunction with her neurosurgeon, a lumbo-sacral exploration was done and a fracture of the inferior facet of the 5th lumbar vertebra on the left side was found. The loose fragment was removed and a fusion was done extending from the 4th lumbar vertebra to

the sacrum. (Figure 4.) One year following the fusion, she no longer suffered back or leg discomfort but was still on a low maintenance dosage of phenylbutazone.

Case No. 3. A 29-year-old female had initially had a herniated 4th lumbar vertebra disk removed on October 31, 1962, by a total hemilaminectomy on the left of the 5th lumbar vertebra, and a subtotal hemilaminectomy of the 4th lumbar vertebra.

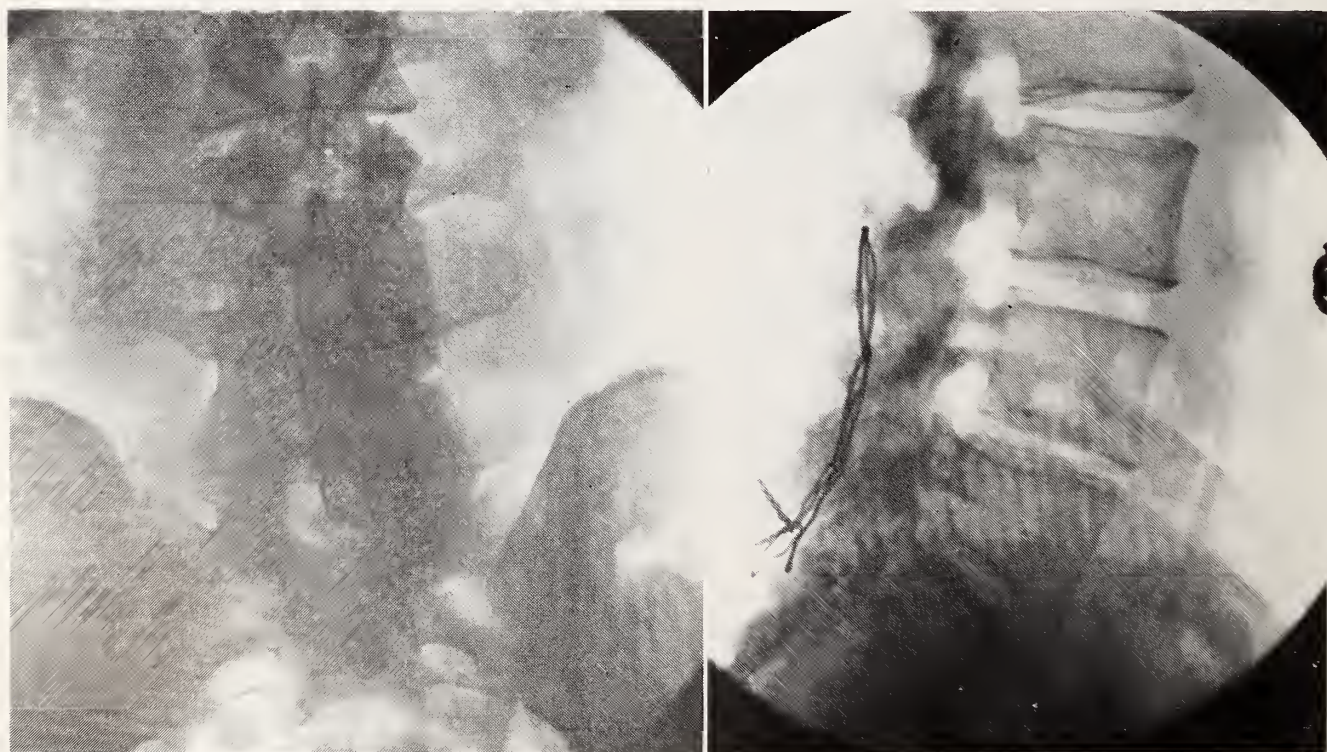


FIGURE 2

Case No. 1.—AP and lateral roentgenograms showing 3rd lumbar vertebra to sacrum fusion seven months after operation.





FIGURE 3

Case No. 2.—AP roentgenogram of lumbosacral area showing sclerosis of osteitic condensans ilii and a fracture of the left inferior facet of the 5th lumbar vertebra. Oblique myelogram roentgenograms did not reveal the facet fracture.

She was quite stoic and had returned to work as a press operator in a factory within six weeks following her operation. She had been without symptoms for two and one-half years, when she was in an automobile rear-end collision and noted instantaneous severe low back pain with extension down the left leg. She was readmitted to the Baptist Hospital by her neurosurgeon for typical sciatica on the left and marked paravertebral muscle spasms. An orthopaedic consultation was obtained. Routine

lumbosacral roentgenograms revealed a fracture of the inferior facet of the 5th lumbar vertebra on the left side. (Figure 5.) The low back was explored, the fractured facet removed, and her low back was fused from the 4th lumbar vertebra to the sacrum.

Six weeks following her operation, she returned to factory work in a low Taylor back brace, and four months following her fusion operation, she had no back or leg discomfort. It appeared by roentgenograms that the fusion was uniting. (Figure 6.)

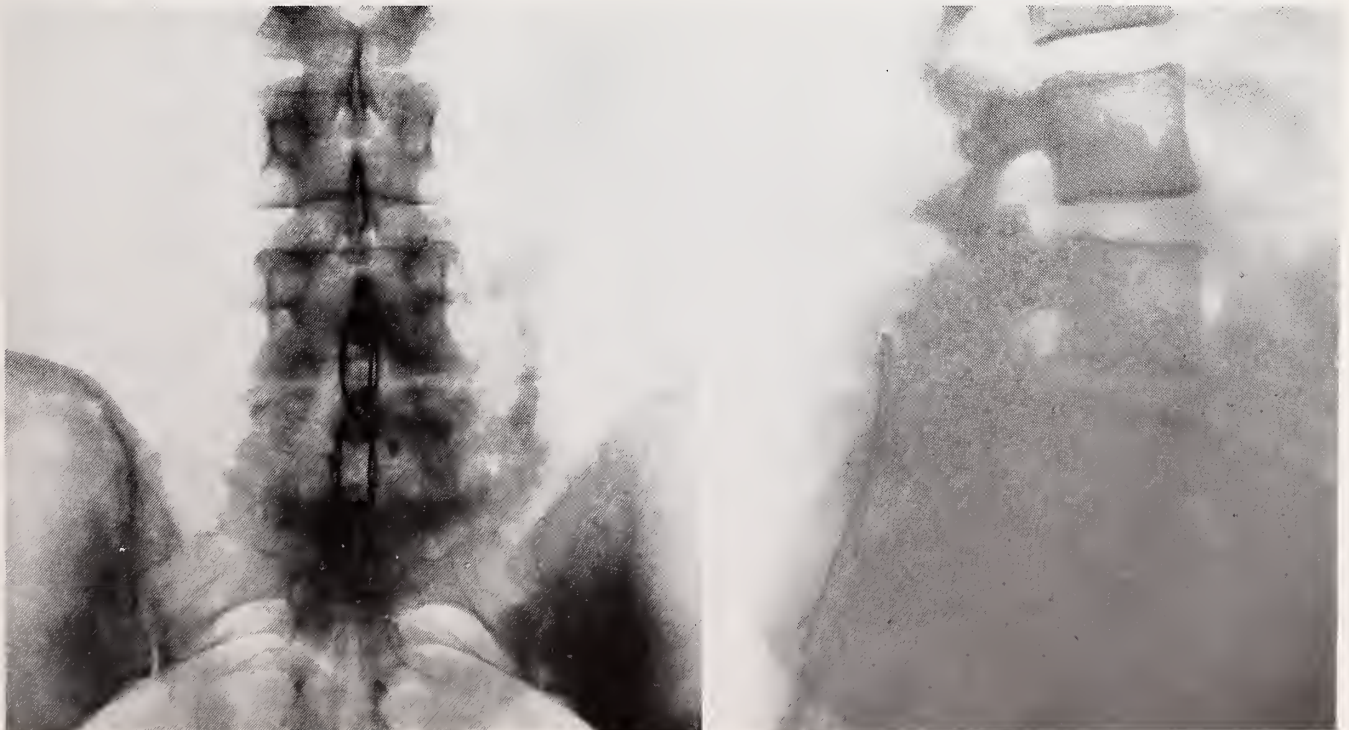


FIGURE 4

Case No. 2.—Fusion mass from 4th lumbar vertebra to the sacrum seven months following fusion operation.



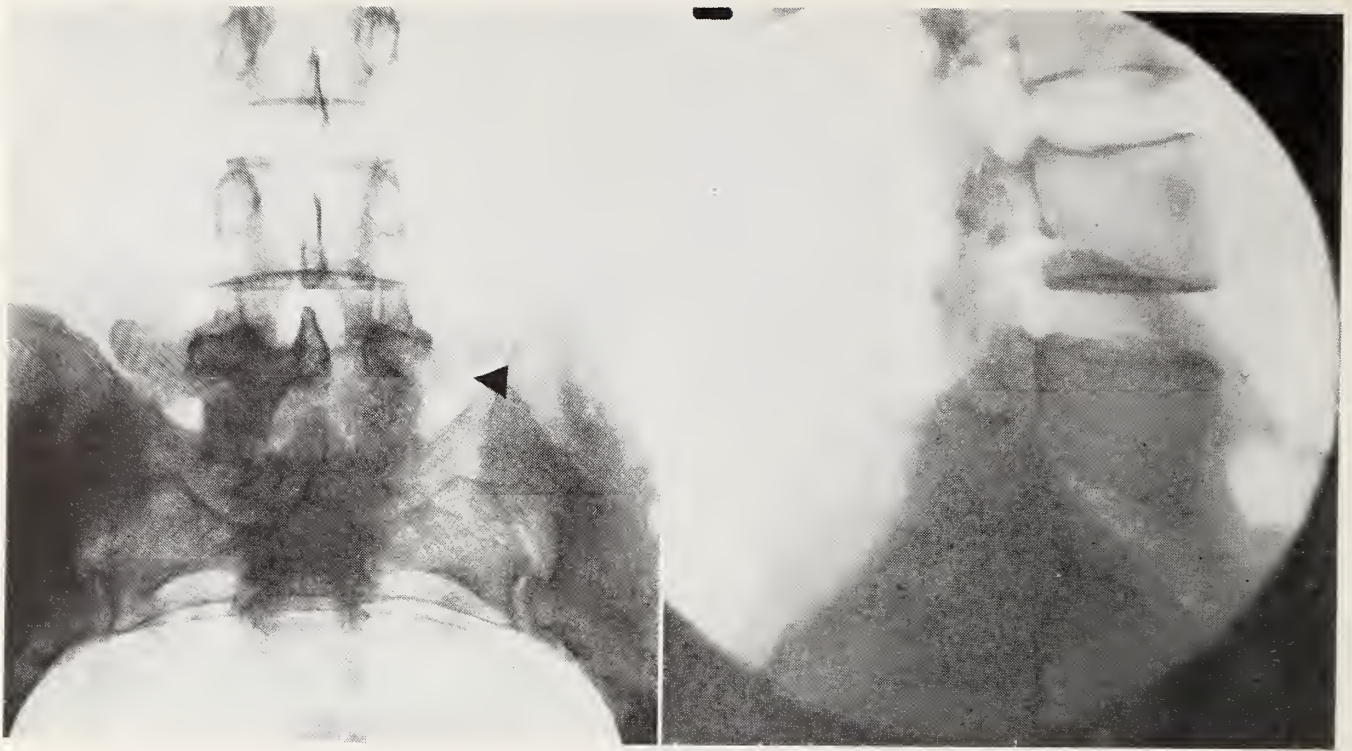


FIGURE 5

Case No. 3.—AP roentgenograms show the fracture of the left inferior facet of the 5th lumbar vertebra. The lateral roentgenograms failed to show the fracture.

Case No. 4. A 54-year-old female was admitted to the Baptist Hospital on June 9, 1965, for recurrent low lumbar muscle spasms and a catch or hitch in her back which was relieved only by bed rest. She had had three explorations of the lower lumbar spine in 1948, 1956, and 1965, the last being only six months prior to this admission. The patient had previously had a total hemilaminectomy on the left side of the 4th and 5th lumbar vertebrae, and a sub-

total hemilaminectomy on the left of the 3rd lumbar vertebra. Routine anteroposterior and lateral roentgenograms (Figure 7) of the lumbosacral area revealed a rotoscoliosis in this area with traumatic arthritic changes in the facets and narrowing of the 3rd, 4th, and 5th lumbar disk interspaces. A diagnosis of a mechanically unstable, irritable lumbosacral spine was made and a fusion from the 3rd lumbar vertebra to the sacrum was advised.

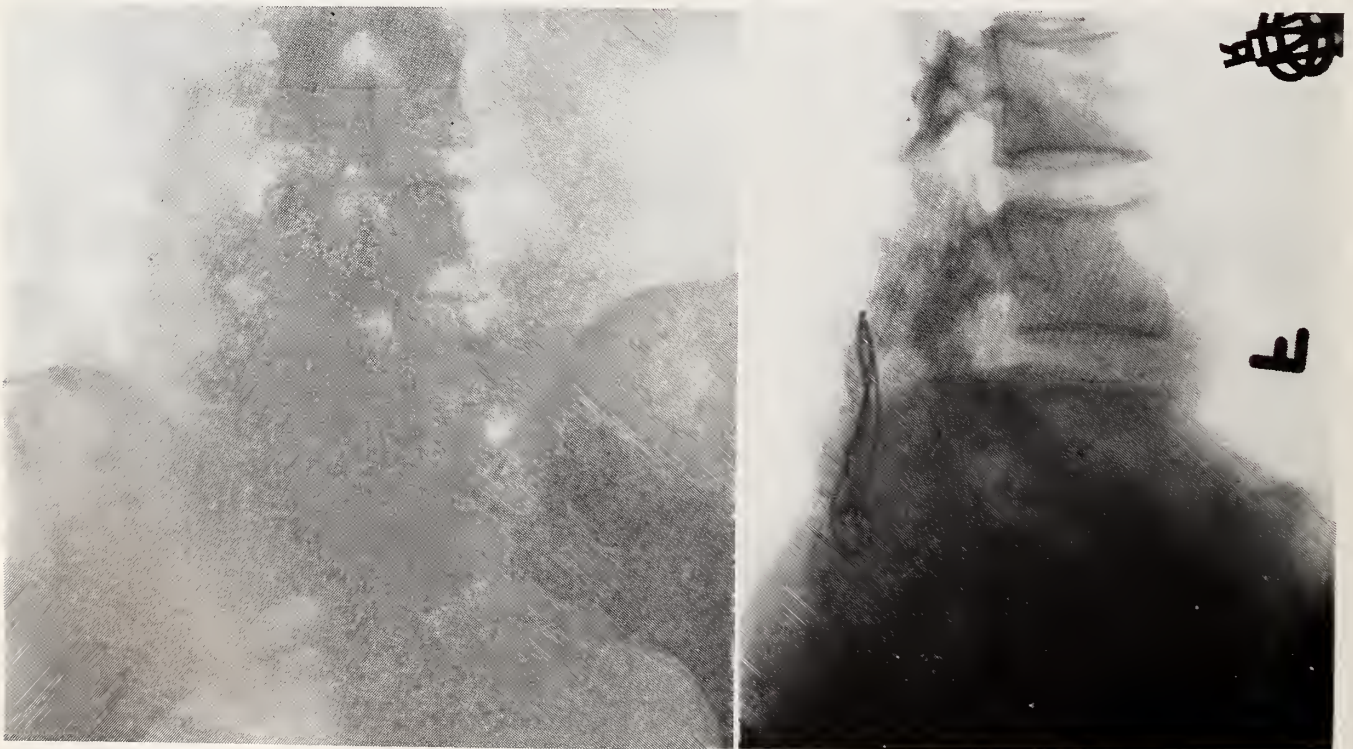


FIGURE 6

Case No. 2.—Appearance of fusion mass four months following operation.



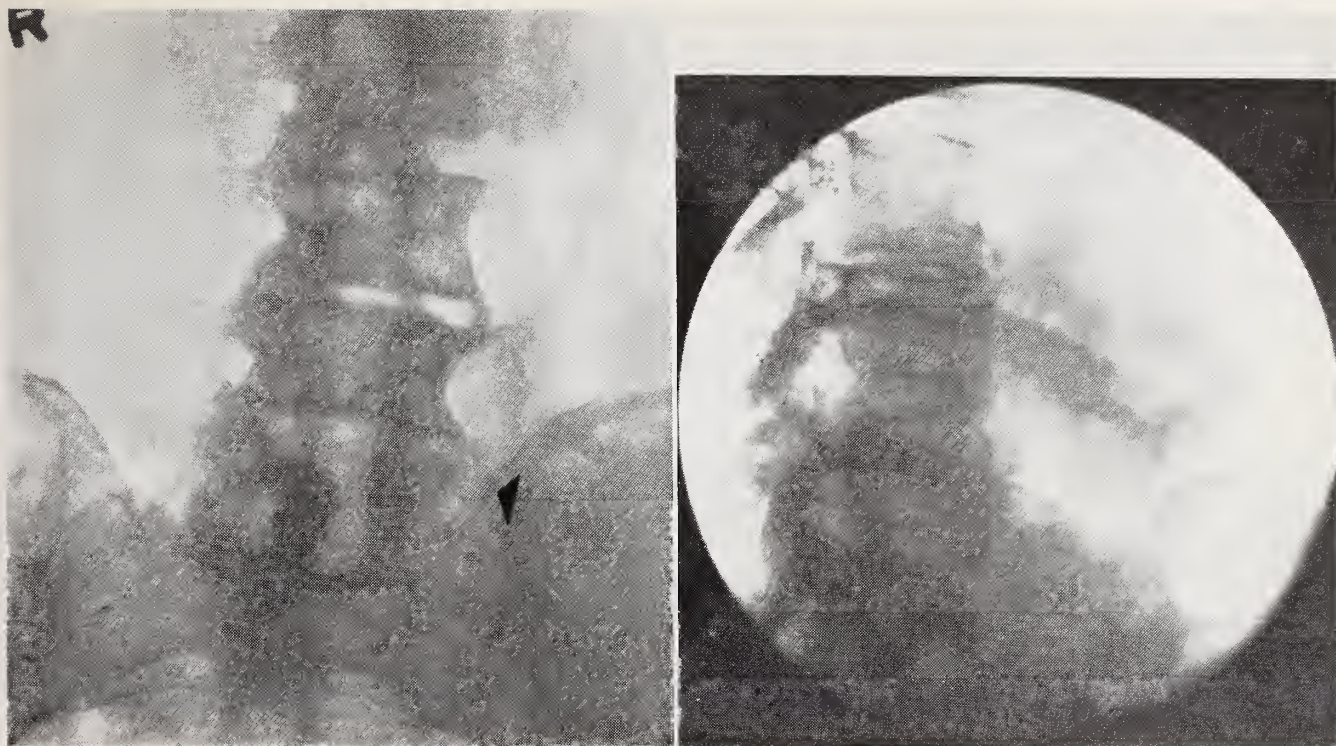


FIGURE 7

Case No. 4.—AP and lateral roentgenograms prior to exploration did not show the facet fracture. The arrow shows the location of the fracture found during the operation.

As the neurosurgeon cleaned the lumbar nerve roots prior to the fusion operation, a fracture of the left inferior facet of the 4th lumbar vertebra was found. The loose fragment was removed and a fusion performed extending from the 3rd lumbar vertebra to the sacrum, utilizing the transverse processes and pedicles of the 4th and 5th lumbar vertebrae and the ala of the sacrum in the fusion.

Roentgenograms made five months following the surgery (Figure 8) showed the fusion mass to be amalgamating. Ten months after the operation she was wearing her brace only on automobile trips, but complained of discomfort over the posterior half of the wing of the right ilium where the bone had been removed for grafting purposes.

In reviewing this patient's film, in retrospect, the



FIGURE 8

Case No. 4.—AP roentgenograms of fusion mass eight months following operation and lateral roentgenograms taken three months following the fusion operation.





FIGURE 9

Case No. 5.—AP and lateral roentgenograms made prior to fusion. The arrow shows the facet fracture at the right superior facet of the 5th lumbar vertebra.

facet fracture could not definitely be seen.

*Case No. 5.* A 52-year-old female was seen at Campbell Clinic in Memphis, Tennessee, on May 24, 1965. She had had two previous operations, at ten month intervals, on her lumbar spine for low back and leg pain. These were unsuccessful in relieving her low back and leg pain.

She had bilateral paralumbar muscle spasms, and decreased tendon jerks of the right knee and ankle,

as well as evidence of sciatic nerve irritation on the right side.

Anteroposterior and lateral roentgenograms of the low lumbar spine revealed a fracture of the superior facet of the 5th lumbar vertebra on the right, a complete removal of the lamina of the 5th lumbar vertebra on the right, a marked rotoscoliosis in the lumbar area convex to the left, and narrowing of the lower three disk interspaces. (Figure 9.)

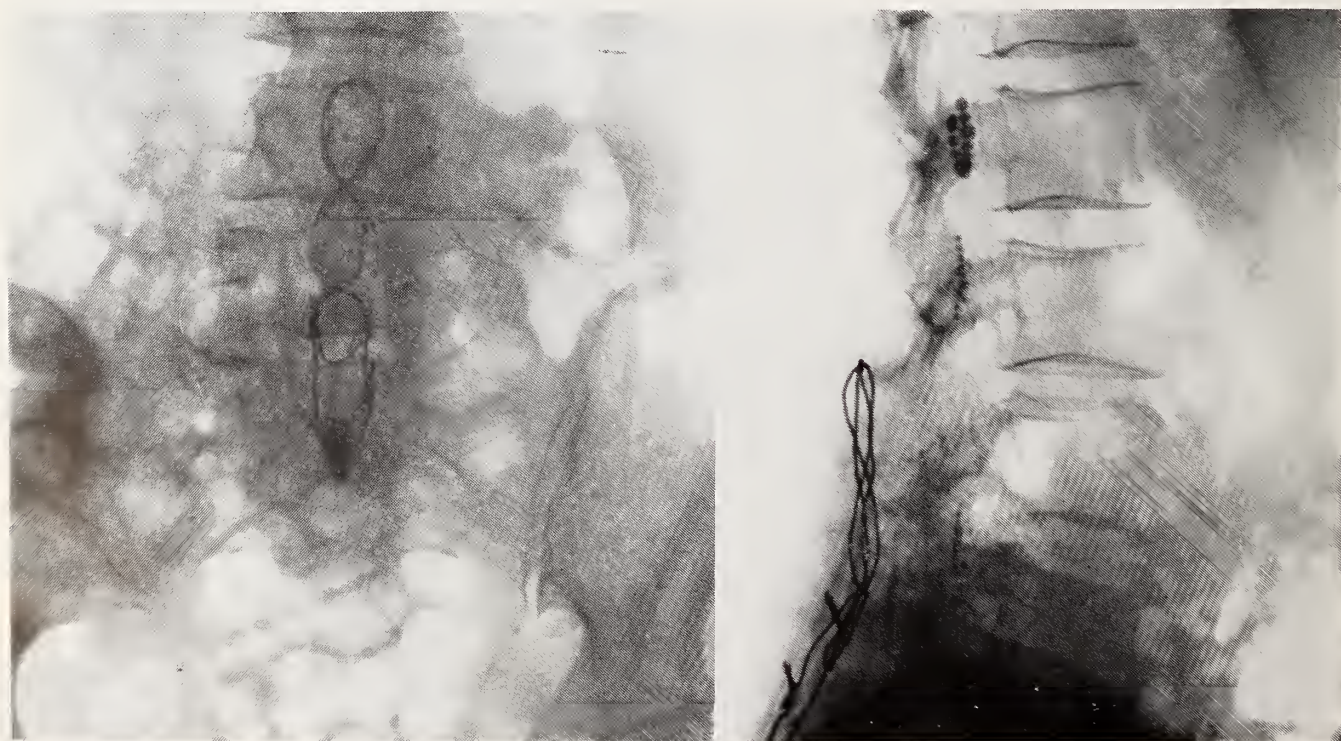


FIGURE 10

Case No. 5.—AP and lateral roentgenograms of the fusion from the 3rd lumbar vertebra to the sacrum made two weeks following the operation.





FIGURE 11

Case No. 6.—AP roentgenograms of the lumbosacral spine showing a fracture of the right inferior facet of the 4th lumbar vertebra.

A low Taylor back brace failed to relieve the patient's pain and on August 10, 1965, the nerve roots at the 4th and 5th lumbar interspaces were explored bilaterally and a partial removal of the 4th lumbar disk was done. During the same operation, she was fused from the spinous process of the 3rd lumbar vertebra to the sacrum, utilizing the transverse processes and pedicles of the 4th and 5th lumbar vertebra and the ala of the sacrum. (Figure 10.)

Eight months after the fusion, her major complaint was pain over the bone donor site.

*Case No. 6.* A 46-year-old male was seen at Campbell Clinic on May 20, 1965, complaining of severe muscle spasms of his low back which could be relieved only by narcotics and bed rest. In 1959, he had had a herniated 3rd lumbar disk removed and exploration at the 3rd and 4th lumbar levels on the right by a subtotal hemilaminectomy. His recovery from the surgery was dramatic. He had been regularly employed as a drug house salesman for four years and traveled almost 1,500 miles each week by automobile.

Two weeks prior to this visit to Campbell Clinic, his back pain had developed spontaneously and was notably different from his previous disk pain.

His examination revealed point tenderness over the lamina of the 4th lumbar vertebra on the right and pain at that point on attempted motion. His lower extremities showed no neurological deficit and no sciatic or femoral nerve irritability.

Routine anteroposterior roentgenograms of the lumbar area demonstrated a fracture of the 4th lum-

bar inferior facet on the right. The facet fracture was not seen, however, on the lateral projection. (Figure 11.)

The patient was placed in a corset to support his back and was entirely asymptomatic within four and one-half months. Anteroposterior roentgenograms made six weeks following his corset immobilization showed evidence of healing of the facet fracture. (Figure 12.)

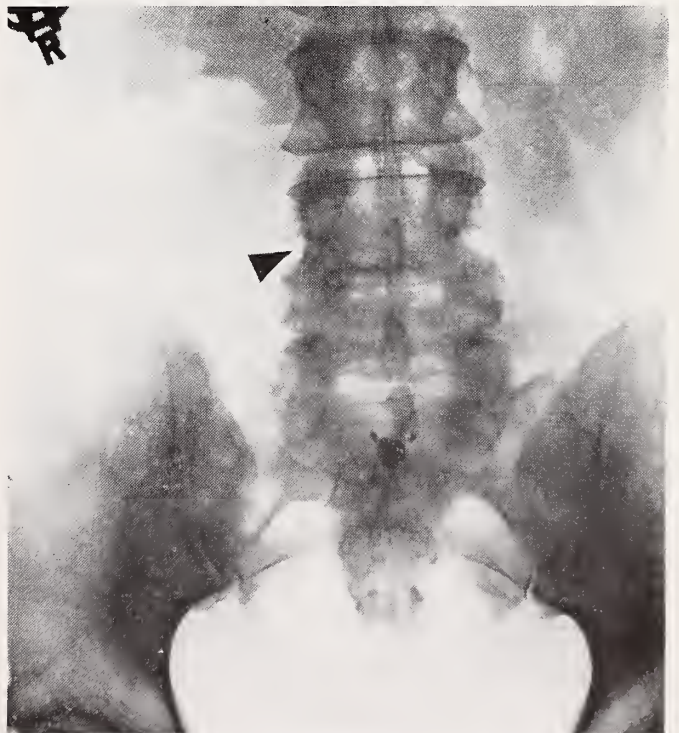


FIGURE 12

Case No. 6.—AP roentgenograms of the lumbosacral area six weeks after corset immobilization shows early healing.



## FACET FRACTURES / Sage

The reason for the facet fractures in these patients is conjectural. One common denominator to all cases is previous disk surgery with the facet fracture occurring on the side of the lamina on which the previous surgery had been performed. Four of the patients had had a total hemilaminectomy at one or more levels (Cases No. 2, No. 3, No. 4, and No. 5). Three of the patients (Cases No. 1, No. 2, and No. 3) had had minor trauma to their backs which initiated the recurrent low back pain. Two of the patients (Cases No. 4 and No. 6) had had spontaneous recurrence without trauma. The remaining patient (Case No. 5) had never been free of back pain. This may possibly be attributed to a fracture of the superior facet of the 5th lumbar vertebra at the time of either of the low back operations.

It seems reasonable that the isthmus of the lamina had been weakened in these patients by removal of a portion of the bone at the time of the disk exploration, and that fractures due to minor trauma had occurred in Cases No. 1, No. 2, and No. 3; and fatigue fractures had occurred in Cases No. 4, and No. 6. The inferior edge of the lamina leading to the inferior facet is that part most often rongeured away, and the inferior facet on the operated side was fractured in all cases except No. 5.

It is difficult to demonstrate the fractures on routine anteroposterior and lateral roentgenograms. In reviewing all of the roentgenograms on these patients, in retrospect, it is possible to demonstrate the facet fractures in five patients, although the diag-

nosis was definitely made preoperatively on only three patients.

Oblique plane roentgenograms, when carefully studied, should demonstrate a facet fracture in most instances. Two surgeons in San Francisco, California,\* who have had similar cases, recommend tomography in the anteroposterior projections, as well as routine oblique projections. Quite possibly, roentgenograms of the area utilizing the magnification technique would be helpful. These roentgenograms are recommended in the study of all patients with recurrent low back pain, with or without sciatic radiation, who have had previous disk surgery. In view of the difficulty in visualizing the fractures by roentgenograms, it is also recommended that the surgeon, while re-exploring a back for recurrent pain, strip the soft tissues subperiosteally wide enough to see the inferior facets to make sure they have not been fractured.

### Summary

The case histories of six patients who had sustained facet fractures following lumbar disk surgery have been reviewed. Five of the patients were treated surgically for this; the fractured facet fragment was removed in four instances, and lumbo-sacral fusion was done in five instances. One patient was treated satisfactorily by corset immobilization.

Special roentgenograms are advised as an aid in diagnosis of this condition.

\* Drs. Francis J. Cox and O. W. Jones, Jr.—personal communication.

## SEPTEMBER "GEORGIA HEART HOUR" TO FEATURE CORNELL PHYSICIANS

The twelfth in the current series of television programs presented by the Georgia Heart Association for physicians will be seen September 5-6 on the Georgia Education Television Network. It is entitled "Renal Disease—Pathogenesis." Guest Faculty: E. Hugh Luckey, M.D., Professor and Chairman, Dept. of Medicine, Cornell University Medical College; David D. Thompson, M.D., Associate Professor of Medicine, Cornell University Medical College; Albert L. Rubin, M.D., Associate Professor of Medicine, Cornell University Medical College; E. L. Becker, M.D., Assistant Professor of Medicine, Cornell University Medical College; and Glenn D. Lubash, M.D., Assistant Professor of Surgery, Cornell University Medical College, Ithaca, New York.

A part of the "Georgia Heart Hour" series, this program will be telecast from 10:30-11:30 p.m., Monday, September 5 and repeated at the same time on Tuesday, September 6.

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tained, free of charge, by writing to: *Medical Association of Georgia, 938 Peachtree St., N.E., Atlanta, Ga. 30309.*



# MEDICAL CIVIC ACTION PROGRAM IN SOUTH VIET NAM

Isaac Goodrich, M.D.,\* *APO San Francisco, California*

“THE AIMS for which we struggle are aims which, in the ordinary course of affairs, men of the intellectual world applaud and serve: the principle of choice over coercion, the defense of the weak against the strong and aggressive, the right of a young and frail nation to develop free from the interference of her neighbors.”\*\* As part of these lofty aims I found myself arriving in South Viet Nam as a battalion surgeon with the First Infantry Division in the Fall of 1965. It was soon apparent that this was a war far different for the battalion surgeon than any previously experienced. Gone were the heavy casualty situations of World War II and Korea. True, there were many casualties on occasion, but usually no more than one to six combat casualties were seen at a time. Instead of a primary surgical and sorting function, the battalion surgeon in this war has assumed more and more responsibilities as an internist and psychiatrist. Another new pattern was the administration of medical treatment on a large scale to the civilian population (including Viet Cong sympathizers sometimes and occasionally “disguished” Viet Cong) in the midst of a combat zone. It is about this program, the Medical Civic Action Program, MEDCAP, that I wish to elaborate.

## Lack of Physicians

Only 100 to 125 medical students are currently graduated each year in South Viet Nam. The overwhelming majority of these are being inducted into the Vietnamese armed forces. There are only about 1,000 native physicians. Around 700 of these are in the Army. Hence, only about 300 doctors are left for the Vietnamese teaching programs and to serve a population of 16 million.

\* Dr. Goodrich is a 1964 graduate of the Medical College of Georgia. Following a straight surgical internship at the Columbia-Presbyterian Medical Center in New York City, he entered the Army as battalion surgeon of the 1st Battalion, 28th Infantry, 1st Infantry Division.

\*\* From speech by President Lyndon B. Johnson at Princeton University in May, 1966.

■ In this combat theatre the battalion surgeon is called upon to administer medical treatment on a large scale to the civilian population.

The general scheme of MEDCAP is for unit physicians, including battalion surgeons, to conduct sick call during regular intervals at villages adjacent to their unit, whether it be at base camp or while out in field operations. Through MEDCAP the physician-to-patient ratio could be improved and better health care for the Vietnamese attained, with its obvious advantage to our cause in winning over the support of the native population. During my first eight months in Viet Nam a total of 2,586 Vietnamese were seen in 39 visits to 14 different villages. The majority of these patients had never been seen by a physician, thereby making the impact of the visits, especially upon the younger age group, more impressive.

## Varying Diseases

What diseases were seen? Accurate diagnosis in many cases was obviously not possible due to the lack of adequate laboratory equipment which could be taken into field operations. Often, symptoms were treated on an educated guess as to what the exact diagnosis would be. The occasional patient who would bring such information with him as a chest x-ray was the exception to the rule. A list of systems involved by symptoms is given in Table I. Ophthalmological conditions seen included conjunctivitis (most common), cataracts, trachoma, glaucoma (open angle form) and two cases of keratitis felt to be due to herpes simplex. The most commonly seen disorder of the ears was otitis media. It was especially prevalent (three out of four cases) in the less than ten year old age group. Cleft lip and palate were occasionally noted. When possible, arrangements were made for transfer of these individuals



to a hospital in Saigon where corrective surgery could be performed. Acute follicular tonsillitis was often present in conjunction with cases of otitis media.

Respiratory Complaints

The most common (one out of four) complaints were referable to the respiratory system. Tuberculosis, bronchitis, asthma and pneumonia were most prevalent. The usual modes of antibiotic and prophylactic therapy were employed. Frequently the results were so dramatic that the facetious remark was often made that in treating children with such disorders as bronchopneumonia, not only was the disease promptly cured, but also growth of a foot or more was induced. Only about 3% of the patients seen had complaints referable to the cardiovascular or genitourinary system. At least two factors serve as an explanation. One, most Vietnamese simply don't live long enough to develop arteriosclerosis and its sequelae. The average life expectancy is between 30 and 35 years of age. Two, the lack of adequate diagnostic tools undoubtedly allowed cases of arteriosclerotic heart disease, congenital heart disease, rheumatic heart disease, chronic pyelonephritis and the like to pass by undiagnosed. I began to sympathize more and more with the hardships the American physician of the 19th and early 20th century had to endure. Still, several cases of congestive heart failure, pulmonary edema, hypertension, acute pyelonephritis and cystitis were seen. A few patients with venereal disease, including one with lymphogranuloma venerum, were seen. Rare is the circumcised Vietnamese male; hence, phimosis was often noted.

Gastrointestinal disorders were among the most common complaints. Nematodes (especially enterobiasis—pinworms), cestodes (tapeworms) and peptic ulcer-like symptoms were prevalent. Again, the majority of these patients responded to the usual



FIGURE I

Respiratory complaints were the most commonly encountered.

TABLE I

System	Number	Percentage
EYE	89	3.4%
ENT	75	2.9
RESP	634	24.5
CV	53	2.1
GI	335	13.0
GU	31	1.2
SKIN	464	17.9
CNS	23	0.9
ORTHO	247	9.6
VITAMIN DEF	384	14.9
OTHERS*	251	9.7

\* Malaria, headache, toothache, abrasions, contusions, etc.

modes of therapy. The second most common group of disorders was dermatological conditions. Among elder patients, basal cell epitheliomas were often seen. Seborrheic dermatitis was extremely prevalent in children less than ten years old. Furuncles, carbuncles, infected abrasions and lacerations and contact dermatitis were all often present. The simple use of soap often reaped near miraculous results.

Neurological disorders were most infrequent. Those seen were usually attributable to trauma (such as transection of the spinal cord by shrapnel) or cerebrovascular disease. However, several cases of classic Parkinson's disease were seen in addition to two cases of neurofibromatosis. Children with the sequelae of poliomyelitis were occasionally noted. Orthopedic complaints were overwhelmingly limited to the "aches and pains" associated with rheumatoid arthritis and osteoarthritis. One advanced case of rheumatoid arthritis with severe flexion contractures was seen. The majority of these patients were in the older age group (50 years and older). Cases of osteomyelitis, clubfoot, kyphoscoliosis and cerebral palsy were also treated.

Vitamin Deficiency

Vitamin deficiency, usually multiple, was extremely prevalent in the less than ten year old age group. The response of attributable dermatitis, weakness, fatigue, myalgia, poor wound healing, stomatitis, glossitis, diarrhea, bone tenderness and deformity to therapy was often remarkably rapid. With the native population on a primary diet of rice and water, protein deficiency was frequently evident also. It was heartening to see the effects of increased meat in the diet of these patients. Neoplasia, unless overtly present (basal cell epithelioma, carcinoma of the lip, etc.), was rarely diagnosed due to lack of adequate diagnostic facilities. If a high index of suspicion was present, these patients were usually referred to a Vietnamese clinic or American clearing station where arrangements for further evaluation could be made. Patients with malaria presented themselves at sick call fairly frequently. The clinical diagnosis in these



TABLE II

Age Group	Number	Percentage
<10	1108	42.8%
10-15	237	9.2
15-35	411	15.9
35-50	316	12.2
>50	514	19.9

usually advanced cases was, as a rule, not difficult with symptoms of characteristic, intermittent chills and fever, splenomegaly, secondary anemia, occasional hepatomegaly and often mild icterus. (The symptoms in American soldiers were far different due to more readily available medical facilities for early therapy, outlook for the disease and rapid, effective treatment. An acute picture of frontal headache, myalgia, generalized malaise, fever and chills was seen in our troops.) The response to chloroquine therapy was adequate in the majority of instances.

The age groups involved are listed in Table II. It is significant to note that over half the patients seen were less than 15 years old, for it is among the young that our hope for the future of Viet Nam is strongest. Relatively few patients were seen in the 15 to 50 year old category. The majority (three out of four) of these were females, most of the males of this age group being either in the South Vietnamese army or the Viet Cong guerilla force.

The opportunity to learn from and help this indigent population was immense. Diseases which have not been prevalent in the United States for many years were seen and treated. A great deal of introspection on my part was required, for the individual whom I treated during the day in sick call might well be the very person to attack Americans, including



FIGURE 2

Intramuscular administration of penicillin to a child with bronchopneumonia.

myself, at night. The principles of the Hippocratic oath prevailed. I found myself functioning as a pediatrician, internist, general surgeon, orthopedist, dermatologist, ophthalmologist, consoler of the hopeless—in short, a generalist in the truest sense of the term. Statistically, it is realized that no great validity should be placed on the figures given here. Adequate follow-up of patients was often lacking. Nevertheless, it does give one a general idea of what the most common complaints of rural Vietnamese are and a goal for improving the extremely poor health conditions in this war-ravaged country.

*Send reprint requests to: P.O. Box 204, Milledgeville, Ga.*

## NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

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## EMORY BEGINS NEW PROGRAM "MASTER OF RADIOLOGICAL HEALTH"

A new program leading to the degree "Master of Radiological Health" will begin in Emory University's School of Medicine this September.

The program is designed to meet the needs for radiological health specialists with an advanced degree in this field.

Dr. Robert H. Rohrer, chairman of Emory's physics department and director of radiological health training, said there is a growing need for specialists with graduate level education who can fill positions in hospitals as radiological physicists, as researchers in university radiology departments, in the growing field of nuclear medicine, and in state and national health departments.

Emory's department of radiology, of which Dr. H. S. Weens is chairman, will staff the new MRH degree program. Dr. Weens initiated Emory's radiological health specialist training and has been a leader in developing national interest in such training.



# PRESENT STATUS OF UTERINE CURETTAGE

William E. Josey, M.D., *Atlanta*

## ■ Clinical indications, techniques, and dangers are outlined and discussed.

INTRODUCED over 100 years ago by Récamier, the operation of uterine curettage remains one of the most useful procedures in gynecology and obstetrics. While additional precision in the diagnosis of intra-uterine disease may be obtained by utilizing various other diagnostic methods, particularly radiographic visualization, such methods cannot serve as substitutes for diagnostic curettage. Moreover, curettage is also frequently of therapeutic benefit. Nevertheless, despite its importance the operation is often lightly regarded. The purpose of this paper is to discuss present-day indications and technique, as well as some of the possible complications.

### Indications

As noted above, the operation of curettage may be either diagnostic or therapeutic. Oftentimes it is both, especially in abnormal uterine bleeding states in the premenopausal woman. With the exception of curettage for completion of abortion, an adequate operation usually requires preliminary dilatation of the cervix. In some patients cervical dilatation may of itself have therapeutic value, as in certain cases of cervical stricture or stenosis. On the other hand, the use of cervical dilatation for palliation in severe primary dysmenorrhea has largely been superseded by the oral progestational agents, which are generally quite effective.<sup>1</sup>

### Incomplete Abortion

Though not necessary in every instance, curettage is advisable in most cases of abortion. Retention of placental fragments is common, and is usually associated with continued bleeding and cramping. Such retention may also predispose to infection. Furthermore, this is a good time to explore the uterine cavity for the presence of a congenital septum and partial duplication of the uterus, a condition which is associated with an increased incidence of abortion, premature labor, and other pregnancy complications. Finally, unless tissue spontaneously passed from the

uterus has been salvaged for pathologic examination, curettage is indicated to obtain confirmation of the presence of normal chorionic villi, thus providing reasonable assurance of the absence of ectopic pregnancy or hydatidiform mole.

In the presence of infection or suspected criminal instrumentation, curettage should usually be preceded by a course of antibiotic therapy for at least 24 to 48 hours, except when necessary to control hemorrhage. Although in recent years immediate operative evacuation of the uterus has been rather widely advocated in abortion with sepsis, the rationale being the elimination of a potential source of bacteremia, no valid evidence has been presented in support of such a policy. Moreover, further dissemination of infection is a possible hazard. Based upon the extensive experience which has been gained at Grady Memorial Hospital in the management of septic abortion, I am in agreement with those<sup>6, 16</sup> who feel that a conservative approach, with prompt and intensive medical therapy, is both safe and effective in the usual case. While actual curettage is to be avoided until infection has been brought under control, simple removal of placental tissue from the already dilated cervix by means of sponge forceps seems desirable and is recommended.

### Therapeutic Abortion

The principle difficulty encountered in performing curettage for therapeutic abortion, particularly in the primigravida, is accomplishing sufficient dilatation of the cervix to enable complete removal of the embryo and placenta. In the event of difficulty, it is prudent to use a two-stage approach, first packing the lower uterine canal with gauze and waiting for about 24 hours to allow the cervix to soften up.<sup>7</sup> Because of the increasing difficulty and danger of performing therapeutic abortion by curettage as pregnancy advances, this method is considered to be contraindicated after the 12th week of pregnancy.

Recently, considerable enthusiasm has been ex-



pressed for the use of intra-amniotic injection of a hypertonic solution (saline or glucose) as an alternative to curettage or abdominal hysterotomy for therapeutic interruption of pregnancy. There are, nevertheless, definite hazards associated with the intrauterine instillation of hypertonic solutions which must be taken into consideration when this procedure is elected.<sup>11</sup> In the opinion of the author, curettage is the procedure of choice, provided this can be carried out in the first trimester.

### Hydatidiform Mole

In the management of hydatidiform mole, it is advisable whenever possible to effect initial evacuation of the uterus by means of oxytocin stimulation, as the uterus is usually very soft and easily perforated in this condition. However, it is important that a thorough curettage be performed before the patient is discharged from the hospital, in order to remove any retained trophoblastic tissue and thus obviate continued bleeding as well as continued elevation of blood chorionic gonadotrophin levels. Persistence or a rise in the chorionic gonadotrophin titer after a period of one month should be considered abnormal, possibly representing malignant change.<sup>4</sup> Investigation by a second curettage is then mandatory.

### Delayed Postpartum Hemorrhage

Because of the ease of perforation of the uterus in the early puerperium, curettage is somewhat hazardous at this time. Moreover, a high incidence of intrauterine adhesions with amenorrhea (Asherman's disease) has been reported as a sequela of curettage performed in the first few weeks after delivery.<sup>2, 5</sup> If removal of placental tissue is required immediately following delivery, this is best accomplished by manual exploration. As a general rule, delayed postpartum bleeding of mild to moderate degree can be managed by non-operative therapy. Oxytocic drugs, combined with bed rest, will usually suffice. Occasionally, however, it may be necessary to perform curettage for late postpartum hemorrhage due to previously unrecognized retention of placental tissue, or to so-called subinvolution of the placental site.

### Infertility

Sampling of the endometrium to determine its histologic pattern, and to obtain evidence of ovulation, is usually readily accomplished by simple office biopsy, using an instrument such as the Novak curette. At times, however, it is preferable to perform a full curettage in the infertile woman, together with a careful pelvic examination under anesthesia.

### Abnormal Uterine Bleeding

Abnormal uterine bleeding, especially prolonged bleeding (menometrorrhagia) or significant intermenstrual bleeding (metrorrhagia), is the most frequent indication for curettage in the nonpregnant patient. During the childbearing years, uterine bleeding is often of the dysfunctional type, especially during the puberal and late premenopausal phases. Benign diseases, such as myomata uteri, cervical polyps, and endometriosis, are also frequent causes in the mature woman. Though much less common, malignant disease must always be considered. In dysfunctional bleeding states, curettage not only helps to establish the diagnosis but also is of therapeutic benefit in from 40% to 60% of patients.<sup>10</sup> A thorough curettage should therefore be the initial step in evaluation and management of most adult women with abnormal bleeding. In the adolescent girl, on the other hand, a trial of progestational therapy is considered to be an acceptable method of management before resorting to curettage, since the overwhelming majority of these patients suffer from anovulation.

A not uncommon but often overlooked cause of abnormal bleeding in patients over the age of 30 is the presence of endometrial polyps.<sup>17, 18</sup> Failure to diagnose and remove such polyps may lead to unnecessary removal of the uterus. These growths are best detected and extracted by means of a special exploring forceps,<sup>12</sup> as described below.

### Postmenopausal Bleeding

Because of the tendency toward oligomenorrhea near the time of the menopause, the question often arises as to whether an episode of uterine bleeding is in fact postmenopausal bleeding or merely a delayed menstrual period. As a rule, any bleeding after cessation of menstruation for a period of six months or more should be considered abnormal and investigated by curettage. Another problem in this regard is the occurrence of withdrawal bleeding in the older patient on estrogen therapy. Generally speaking, if vaginal bleeding cannot be clearly related to hormonal therapy, or to local conditions such as atrophic vaginitis, curettage is indicated in order to rule out malignancy.

It has been demonstrated that office biopsy of the endometrium can be a useful screening procedure for the detection of endometrial carcinoma.<sup>8</sup> However, there is general agreement that hospital curettage is indicated when the findings are negative in a symptomatic patient. It is also to be emphasized that routine cervico-vaginal cytologic smears, which are highly effective in the detection of carcinoma of the cervix, are relatively unreliable for endometrial cancer diagnosis.



### Pelvic Tuberculosis

Though now rare in the United States, pelvic tuberculosis should be suspected in the presence of refractory adnexal inflammatory disease as well as in patients with otherwise unexplained infertility, especially when there is a history of extragenital tuberculosis. In some instances the diagnosis can be made only by laparotomy, but curettage (preferably carried out in the premenstrual phase of the endometrial cycle) is the most valuable diagnostic procedure available. Accuracy in diagnosis is enhanced by bacteriologic as well as pathologic examination of curettings.<sup>10</sup>

### Technique

Although simple biopsy of the endometrium can usually be performed as an office procedure, the anesthetic requirements for cervical dilatation and systematic curettage generally dictate admission to the hospital. Use of a general anesthetic has the added advantage of facilitating a careful pelvic examination. In some hospitals arrangements have been made for performing this and other minor gynecologic procedures on an outpatient basis. The advantages in this type of program, as well as the necessary safeguards, have been discussed by Vermeeren *et al.*<sup>21</sup>

A definite ritual should be followed in performing curettage.<sup>20, 22</sup> After emptying the bladder, pelvic examination is carried out. The patient is then prepared and draped, and the cervix grasped with a tenaculum. A uterine sound is inserted to determine the depth, direction, and regularity of the uterine canal. Normally 6 to 8 cm. in length in the nulliparous or postmenopausal woman, the canal is usually 8 to 9.5 cm. in the multipara. Knowledge of the direction of the canal is important in preventing accidental perforation, which is more likely in the acutely flexed uterus.

After the cervix has been dilated—preferably by means of a set of cylindrical dilators, and only to the extent necessary to perform the required intrauterine manipulations—exploration of the uterine cavity is carried out with a special “polyp forceps.” A one-quarter curved kidney stone forceps is an excellent instrument to use for this purpose. In addition to providing an effective means of identifying and removing endometrial polyps, such an instrument is also useful in detecting abnormalities such as pedunculated submucous myoma and congenital septate uterus.<sup>12</sup> A systematic curettage is then carried out, avoiding overly vigorous strokes which might lead to perforation. If carcinoma is suspected, or if radium is to be inserted for treatment of malignancy,

a fractional curettage is performed, scraping the endocervical canal first. Following curettage the uterus is re-explored in order to search for missed polyps and to remove any loose endometrial tissue. Finally, in performing diagnostic curettage, several biopsies of the cervix are obtained at the squamo-columnar junction and endocervix. All specimens should be carefully preserved and placed in separate, properly labelled containers before being sent to the pathology laboratory.

### Hazards

*Immediate Hazards.* The chief immediate hazard is perforation,<sup>3, 19, 20</sup> which is favored by acute flexion of the uterus, postmenopausal atrophy, pregnancy, and malignancy. Proper preventive measures include a careful preliminary pelvic examination to determine the size, shape, consistency, and position of the uterus. Administration of an oxytocic to improve uterine tone is an important precautionary step when curetting the postabortal or puerperal uterus. While most simple perforations do not cause serious injury and require no special treatment, trauma to the bowel or bladder may occur. If perforation is suspected the operation should be halted at once in order to minimize the likelihood of causing serious damage to pelvic structures. Postoperative observation of the patient for a period of 24 to 48 hours is then advisable.

Careful studies of uteri removed immediately after dilatation and curettage have shown that the cervix is torn to some extent during dilatation in a significant proportion of cases.<sup>9</sup> Although frank hemorrhage is rare, unrecognized trauma may be an important factor in some of the remote sequelae.

The possible danger of performing curettage in the presence of intrauterine or pelvic infection has previously been mentioned.

*Remote Hazards.* Possible remote hazards include intrauterine adhesions and amenorrhea (particularly after postpartum curettage),<sup>2, 5</sup> incompetent cervical os,<sup>15</sup> rupture of the uterus in a subsequent pregnancy,<sup>14</sup> and development of endometriosis at the site of uterine perforation.<sup>13</sup> Such sequelae may be more common than is generally appreciated, but can be minimized by attention to proper technique and precautions in the performance of the operation.

### Summary and Conclusions

The operation of uterine curettage remains a very important diagnostic and therapeutic procedure in the practice of gynecology and obstetrics. Present-day indications, technique, and potential dangers have been discussed. Attention to the finer points of the operation will reward the clinician with much



useful information, increase the therapeutic effectiveness of curettage, and avoid most of the pitfalls.

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Department of GYN-OB  
Emory University School of Medicine

1966 CALENDAR OF MEETINGS

State

August 25-27—West Virginia State Medical Association, The Greenbrier, White Sulphur Springs, W. Va.  
September 18-20—Ninth Annual Medical Progress Assembly, Birmingham, Ala.  
September 19-20—Eighteenth Annual Scientific Sessions of the Georgia Heart Association, Aquarama, Jekyll Island, Ga.  
September 26-27—Tennessee Valley Medical Assembly, Trivoli Theater, Chattanooga, Tenn.  
September 29-30—Seminar on Diabetes sponsored by the Florida Diabetes Association, Deauville Hotel, Miami Beach, Fla.  
April 30-May 1-2, 1967—113th Annual Session of the Medical Association of Georgia, Marriott Motor Hotel, Atlanta.

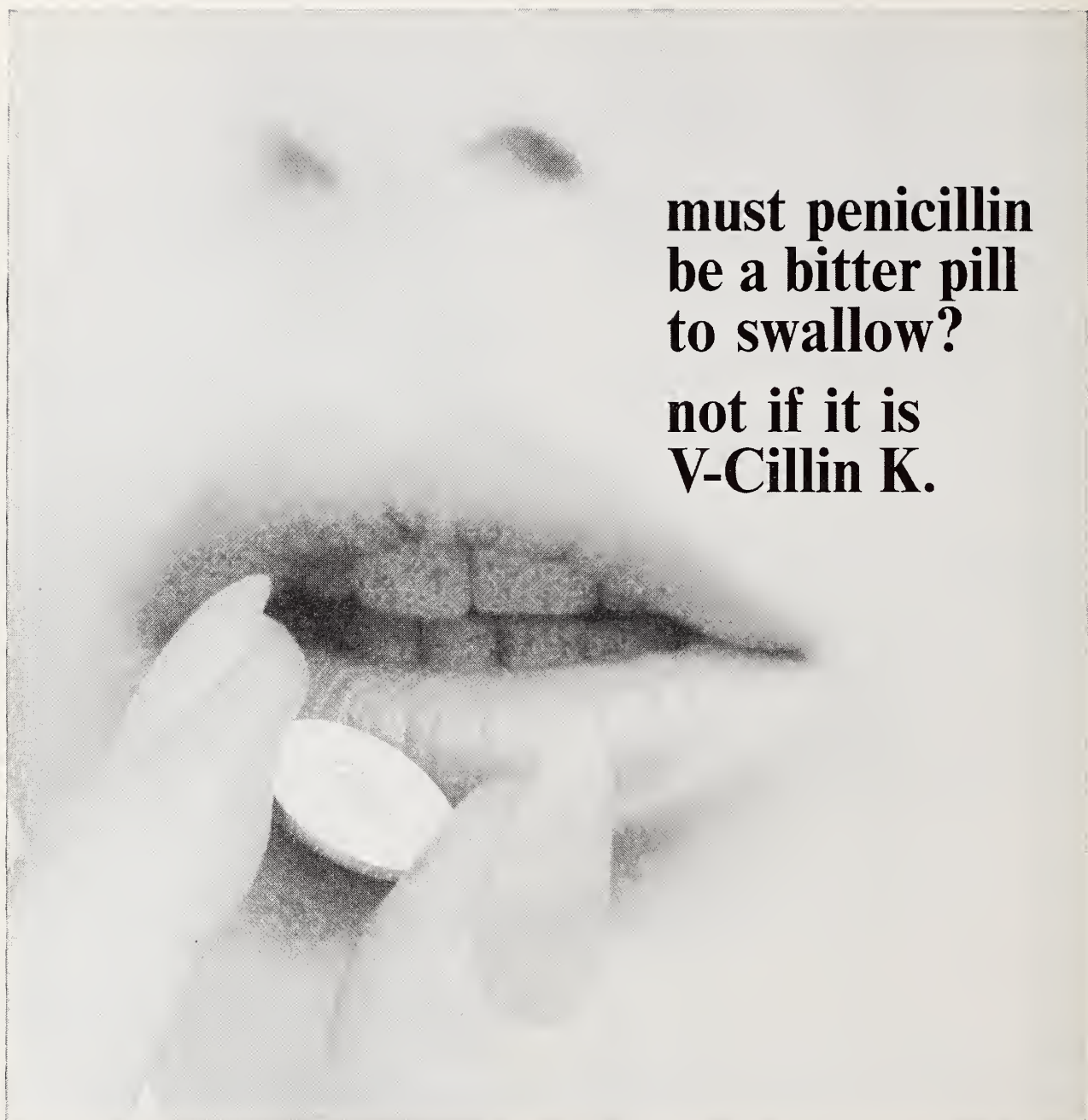
Regional

August 18-20—Nineteenth Annual "Postgraduate Obstetric-Pediatric Seminar," sponsored by the Children's Bureau, Maternal Welfare Committees and Bureaus of Maternal and Child Health of the State Health Departments of Georgia, Alabama, Florida, Mississippi, South Carolina, and Tennessee at Daytona Beach, Fla.  
August 24-26—Thirteenth Western Cardiac Conference, "Ischemic Heart Disease," University of Colorado Medical Center, Denver, Colo.

National

August 26—Medical Assembly of the Muscle Shoals Branch of the Alabama Chapter, American Academy of General Practice, Turtle Point Yacht and Country Club, Florence, Ala.  
September 8-10—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.  
September 16-17—Otolaryngology Seminar sponsored by the College of Medicine, University of Florida, J. Hillis Miller Health Center, Gainesville, Fla.  
September 22-24—The American College of Cardiology Regional Meeting; and the Fifth Annual Cardiovascular Seminar, "Cardiovascular Emergencies," sponsored by the College of Medicine, University of Florida, J. Hillis Miller Health Center, Gainesville, Fla.  
October 1-7—The Annual Otolaryngologic Assembly of 1966 sponsored by the Dept. of Otolaryngology of the College of Medicine of the University of Illinois, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.  
September 15, 1966-June 15, 1967—Nine month tutorial program in Cardiology offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.  
October 7-14—American Academy of General Practice, War Memorial, Boston, Mass.  
November 27-30—American Medical Association (Clinical Convention), Las Vegas, Nev.





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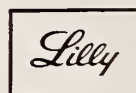
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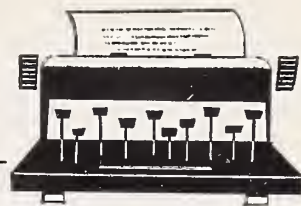
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## Spontaneous Regression of Cancer And Long Term Recrudescences

### INTRODUCTION:

Spontaneous regression of cancer is a very intriguing and challenging phenomenon, which has been mentioned as a probability or fact by numerous writers in the field of oncology, but proof of its existence is difficult to obtain. Very few writers have ventured a statement relative to its frequency, but Bashford<sup>1</sup> has estimated that it occurs once in 100,000 cases of cancer and Boyers<sup>2</sup> once in 20,000 cases. Southwick states that the term "spontaneous regression" is a misnomer, because the regression is actually secondary to a change in the patient's resistance rather than a spontaneous development. However, since the cause of this change is unknown, a truly satisfactory scientific term has not been suggested.

### Does Phenomenon Occur?

Some authors have expressed serious doubt that the phenomenon ever occurs. Many of these authors point out that the numerous reports in the literature cannot be accepted categorically as instances of spontaneous regression of cancer because of lack of biopsy control at critical points somewhere along the course of observation. Others such as Ewing<sup>3</sup> state the presence of "shadows," no matter how suggestive they may be even when cancer is present in other parts of the body, cannot be finally accepted as evidence of metastatic cancer without cellular confirmation of their nature, especially when they no longer become apparent if the primary lesion is removed. Finally, many antagonists of the occurrence of spontaneous regression argue that treatment which might have been regarded as ineffective cannot always be disregarded as exerting an influence. Dunphy,<sup>4</sup> Stewart,<sup>5</sup> and others emphasize the probability of the existence of such occurrences and have emphasized the importance of their recognition as a means of adding to our knowledge of environmental variations in the tumor-host relationships. Shimkin<sup>6</sup> points out that, "statistical analysis of final results on

sufficient numbers of adequately controlled cases is the only method by which prolongation of life, or cure, can be acceptably substantiated." He also states that such an analysis involves "comparison of adequate groups of treated patients with similar groups of untreated "controls," or at least with groups treated by some other method but similar in regard to sex, age, stage of disease, and other characteristics which could be designated as "contratests." Smithers<sup>7</sup> supports Shimkin in his emphasis of the need for statistical support of "cured patients." He feels that individual cancer patients who have survived for many years following certain therapeutic measures are all too often discussed with implications that the measures adopted may have been responsible for the protracted survival. He states that, "knowledge regarding the natural history of the disease should discourage acceptance of such implications not supported by statistical evidence."

### Discussion

Scattered through the literature, a series of remarkable cases indicate how unpredictable cancer is as a disease and how progression in fully developed neoplasms is by no means uniform in all patients. Fluctuations in growth, occasional decreases in size of the masses, necrosis, and hemorrhage resulting from interference with the vascular supply of the neoplasm, and partial clinical improvement for varying periods of time are infrequent but not rare clinical occurrences. For example, "in the lymphoma group of neoplasms, temporary and partial remissions without therapy are seen in up to 10% of the cases."<sup>8</sup> Even complete regressions of fully developed cancer without recurrence and without therapy have been recorded, but acceptable cases of this type are certainly medical curiosities. For practical purposes, the course of untreated cancer in man is considered to be one of inexorable growth, spread, and fatal termination. However, as previously noted, this progression is not uniform and may vary according to specific type and site of the cancer. It may vary widely



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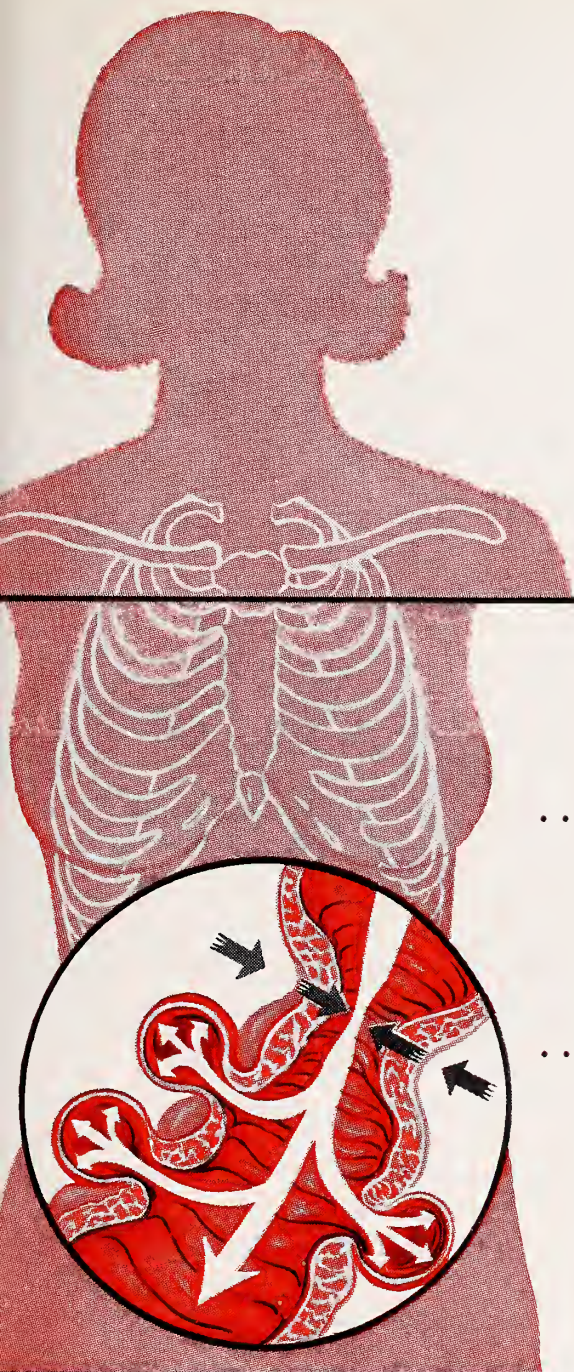
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## Metamucil

- ... to counteract the constipation which is etiologically important and
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**SEARLE**

*Research in the Service of Medicine*



in different patients. Even without therapy a considerable proportion of patients with some types of cancer survive for long periods.

In any series of untreated cases there will be certain ones with much longer survival than the average. Some apparently show spontaneous disappearance, either of the primary tumor or of secondary implants.

The present wide use of surgery, radiation, and other measures in the treatment of cancer, particularly in areas and centers where the diagnosis is achieved with high accuracy, precludes satisfactory statistics on untreated cases. According to Homburger the occasional untreated cases from such sources are usually from a highly selected group of patients with advanced disease at the time of diagnosis. He states that, "direct comparison between groups treated by different methods is also often negated because the form of therapy in individual cases is usually chosen on the basis of some specific indications, thus introducing an element of selection."

### Regression

As early as 1918, Rohdenburg,<sup>9</sup> collected 302 cases of cancer with temporary or permanent regression. However, Homburger later reviewed these cases and found only 100 acceptable as "complete recession of malignant tumor carefully controlled." In at least three of these reported cases there was complete disappearance of an advanced histologically substantiated neoplasm, and eventual necropsy failed to reveal persistence of recurrence. One example cited was a woman of 37 who had a pelvic spindle-cell sarcoma with peritoneal implants. She was treated by hot air baths and died without evidence of tumor 20 years later. Also, a case was cited of a male with advanced gastric carcinoma, with peritoneal metastases, who died two and one half years later without evidence of neoplasm. The third was a patient with chorioepithelioma with extension into the pelvis, who died one year after partial removal of the mass; no recurrence was demonstrable at autopsy. Rohdenburg analyzed the factors that he felt may have been involved in the regression in 217 cases. Incomplete operation, possibly leading to occlusion of the vascular supply, was performed in 69 patients; "heat," either externally applied or resulting from infection, was present in the history of 91 patients; and in 27 patients regressions followed general acute infections such as erysipelas, tuberculosis, or pneumonia; fibrosis or calcification was suggested as the cause of regression in seven cases.

Everson and Cole<sup>10</sup> have reported an extensive review of the literature endeavoring to assess the

validity of cases of spontaneous regression. They initially reviewed over 600 cases but could consider only 47 to be sufficiently documented with adequate history and accompanying microscopic findings to justify inclusion in their series. They discarded the remainder because microscopic confirmation was lacking or because more than insignificant therapy had been given the patient. Permanent regression, in their review, was not considered essential though it occurred in a few of the primary tumors noted. Temporary regression, where there was a marked diminution in size of the tumor mass for a significant period of time, was also considered acceptable.

The most frequently reported regression by these authors was neuroblastoma (25 cases) and almost 80% of the regressions were in infants who were less than one year old when first observed. They commented that since only about one-third of the neuroblastomas occur in the first year of life, "there would seem to be some environmental variation present in some of these young individuals to modify the course of the disease." Phillips<sup>11</sup> substantiated their findings and stated that, "regression of neuroblastoma in children occurs with sufficient frequency to be considered as a definite feature in the natural history of the disease." Fourteen patients with hypernephroma experienced regression, as did 13 patients with choriocarcinoma and ten with malignant melanoma. Regressions in other forms of malignancy were less frequently encountered as can be seen in the following table taken from their review:

Neuroblastoma—25
Hypernephroma—14
Choriocarcinoma—13
Malignant melanoma—10
Soft tissue sarcoma—9
Bladder—7
Osteogenic sarcoma—6
Breast—5
Colon and Rectum—4
Uterus—4
Miscellaneous—23
(malignant teratomas, lymphosarcoma, stomach, etc.)

More recently the study has been extended so that they now have 120 authenticated cases.

### Environmental Variations

These authors, like Rohdenburg, attempted to assay the many factors which appeared to contribute to the occurrence of the regressions observed, and, with the exception of unsuspected complete surgical removal, classified them under the broad heading of environmental variations. The removal of the primary tumor seemed to be the major variation in the



regressions noted in the hypernephromas and choriocarcinomas. In all but one of the patients with choriocarcinoma, the metastatic tumor regression was observed to occur after the removal of the primary tumor. The pulmonary metastasis in 11 of the 14 patients with hypernephroma who experienced tumor regression was noted after nephrectomy. As regards environmental variations, the authors stated that, "environmental variations when not exogenously induced may modify host resistance and theoretically result in spontaneous regression." They included such variations as endogenous endocrine influences, acquired infections, allergic reactions, and inadequate treatment. One melanoma case regressed after a second pregnancy, while another regressed following treatment with antirabies vaccines. Also, various chemical compounds, not generally effective for a given tumor, were occasionally found to be associated with tumor regression.

Closely allied to the topic of spontaneous regression is the problem of long-term recurrences, especially in the form of distant metastases after apparent successful removal of the primary growth. Willis<sup>12</sup> records some 30 such cases. Morton and Morton<sup>13</sup> in 1953 gathered 17 patients of this type and reviewed the general topic of long symptom-free survival with cancer. The authors felt that the cases probably represented "the physiological control of growth by the host." Dunphy<sup>14</sup> pointed out that some cancers seem to grow in cycles with times of rapid growth alternating with stationary periods or actual remissions. Brunschwig<sup>15</sup> reported several cases demonstrating this phenomenon of delayed recurrence where the tumor reappeared years later in the scar of the previous operation or in its immediate neighborhood. He stated that, "sometimes the metastatic cells seem to have remained dormant in the lymph nodes or in organs of the body without ever producing symptoms. Sometimes after such a resting period the tumor cells seem to regain their vigor and flare up anew with rapid growth throughout the body." This balance between the growth rate of the tumor and the resistance of the host has been of interest for several years. Morton and Morton<sup>16</sup> feel that this phenomenon may indicate that cancer may behave as a chronic disease. They summarize a variety of cancers, showing that chronicity is not confined to any particular type.

This "latent carcinomata" referred to by Sir Taylor<sup>17</sup> apparently attests to the fact that there are unknown forces which can keep cancer cells dormant in the vicinity of the excised primary tumor or in the lymph nodes or distant anatomical regions for a great number of years before their resurgence point to a great auxiliary defense power resident in the host in some cases. Sir Taylor called this auxiliary

defense power "the incomputable factor in cancer prognosis."

Such ideas of a natural resistance have stimulated much research into the immunologic phenomena associated with cancer. According to Stewart<sup>18</sup> the existence of an immunological factor in the body's defenses against malignant tumors seems certain, even though it often fails to prevent the death of the patient. Enough cancer cells resistant to the defenses survive to kill. Stewart feels the possibility remains that ways might be found of enhancing or exploiting the immune response. Beswick<sup>19</sup> states that examples of unexpected survival in cancer are naturally a source of encouragement, but may prove to be more than this, "they may provide a clue to the elucidation of immunological phenomena associated with cancer."

Latent carcinomas and spontaneous regressions have been reported for almost every type of malignancy. For example, the behavior of no other tumor is so unpredictable as that of a melanoma. Only rarely is a frankly malignant growth cured by excision and it has been said of malignant melanoma that it is "virtually a death warrant." However, McClure,<sup>20</sup> Pringle,<sup>21</sup> and Allen,<sup>22</sup> to name but a few, have recorded cases of spontaneous regression.

## Conclusion

The occurrence of spontaneous regression renders untenable the hypothesis that "cancer is a progressive, lawless, autonomous growth dependent upon the host for its blood supply."<sup>23</sup> It implies that some of the many factors, exogenous and endogenous, that may lead to neoplasia in the first place are essential for progression of the lesion. Apparently the alteration or withdrawal of these factors, even in advanced stages of the disease, can result in dissolution of the tumor. This concept, if correct, is of the utmost importance because it allows for a natural resistance to neoplasia on the part of the organism and implies that the total destruction of every cancer cell is not necessarily essential for five-year or ten-year survival. The clinical evidence of a natural resistance is only circumstantial. However, as pointed out previously, it can be inferred from the development of the recurrences, the regression or arrest of tumor in one site while it is progressing elsewhere, and the occasional explosive spread of cancer.

It is felt that patients who present spontaneous regressions of cancer are subjects who should be intensely studied and constitute a challenge to those interested in the biology of neoplastic disease in order to elaborate newer concepts and techniques for the elucidation of these phenomena. Brunschwig<sup>24</sup> has suggested "a registry for living patients whose histories are acceptable for instances of spon-



## EDITORIALS / Continued

taneous regression in order to afford available human subjects for special studies as techniques for such investigation are developed." This would certainly be valuable.

Spontaneous regression of cancer is exceptional—all the more reason for studying it. Exceptions are always promising material for further investigation.

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\* Jerry O. Weaver, M.D.

\* Dr. Weaver is a 1966 graduate of the Medical College of Georgia and is currently serving an internship at the U. S. Naval Hospital in Portsmouth, Virginia.

## Highlights of AMA Annual Convention

The following summary of the activities of the AMA House of Delegates is given only for the purpose of touching upon the more important items undertaken at the 1966 Annual Convention. It is not intended as a detailed report of all the actions taken.

THE HOUSE OF DELEGATES received and considered a large number of reports and resolutions dealing with Medicare, the expanded Kerr-Mills program under Title 19 of Public Law 89-97 and other federal laws or programs.

In accepting a Board of Trustees report on Medicare, the House recommended that "the Association give wide dissemination to the information contained therein, particularly its informed discussion of direct billing, the basic purposes of utilization review, the rejection of compensation for service on such committees except in exceptional circumstances, and the proper placement of any onus of responsi-

bility for any failure in the Medicare program."

The Board report ended:

"During the past year many individuals have represented the American Medical Association and the physicians of the United States by meeting frequently with officials of the Department of Health, Education and Welfare. This degree of cooperation on our part should be viewed as a recognition by responsible citizens of an obligation to obey the law of the land, including this law with which we disagree. Our specific purposes have been to provide expert assistance to the government so that this law could be implemented in a manner most helpful to the beneficiaries



while disturbing the practice of medicine to the minimum degree. Despite our best efforts it is apparent that serious problems are inevitable in connection with the implementation of this law and we trust that the physicians and the public will place the blame for such deficiencies squarely where they belong—on the Federal Government.”

### Physicians' Billing Procedures

In connection with the Medicare part of Public Law 89-97, the House adopted three resolutions which recommended physicians use the direct billing method rather than the assignment procedure. At the same time, the House pointed out that adoption of these resolutions should not be interpreted as contravening the statement approved at the Special Session in October, 1965, which said:

“The American Medical Association opposes any program of dictation, interference or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97.”

In considering a resolution on the right to bill patients under Title 19 of the law, the House passed an amendment pointing out that direct billing has been recommended as the billing method of choice under Title 18 by the Board of Trustees and the Council on Medical Service. It then said that since there is a wide latitude available to the states in establishing administrative procedures under Title 19, each state medical association should work early and diligently in its own state so that any plan or law adopted in its state for approval under Title 19 would include authorization for direct billing.

### Hospital-Based Physicians

The House passed two resolutions involving billing and reimbursement principles affecting hospital-based specialists but also of significance to all physicians. The first said:

“The Principles of Medical Ethics declare that a physician shall not dispose of his services to a third party or ‘lay’ organization, and

“Title XVIII of Public Law 89-97 recognizes the principle of the separation of professional and hospital costs for services rendered by hospital-based physicians; and

“This principle has been advocated by the AMA, the American College of Radiology, the American College of Pathologists, and many regional organizations, and

“A great number of hospital-based physicians throughout the nation have declared their intention to bill separately for their professional services

in keeping with this principle; therefore be it.

“*Resolved*, That, since separate billing by the physician for his professional services is a preferred ethical practice, it shall be deemed unethical for a physician to displace a hospital-based physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing.”

The second resolution regretted that publication of *Medicare Regulations* #5 was delayed until June 28, three days before the effective date of Medicare, and said that these regulations do not conform to the intent of Congress as expressed in Section 1801 of the Medicare law. It then declared that:

“The House of Delegates instruct the Board of Trustees and the Executive Vice President to request from the Social Security Administration an extension of date of final adoption of the proposed regulations of not less than 90 days, in order that the American Medical Association and all other interested medical organizations be allowed reasonable time to study, and to submit, to the Social Security Administration, data, views or arguments and pertinent constructive comments and suggestions.

“To preserve the professional independence of medical practice that the Board of Trustees and Officers of the AMA be instructed to immediately inform the membership that Medicare Reg. #5 will not apply to physicians (whether hospital-based or not) who

“1. have no financial relationship with a hospital covering medical services to patients

“2. do not accept assignments but bill directly.”

### Medical Ethics

In acting upon a Board of Trustees recommendation the House adopted a statement to the effect that a physician may participate in the ownership of a pharmacy or regularly dispense drugs, remedies or appliances or provide eyeglasses to his patients *only when approved by his component and constituent medical associations and when it is determined by them to be necessary in the best interests of the patient.*

### AMA Dues Increase

By a vote of 168 to 46, the House approved an increase in AMA annual dues from \$45 to \$70, effective January 1, 1967, thus confirming a Board of Trustees recommendation which was given initial approval at the 1965 Clinical Convention.

The House, in approving the dues increase, accepted a reference committee statement which said in part:

“It is quite apparent that the programs necessary to serve the needs of the members of the Association



## EDITORIALS / Continued

cannot be conducted effectively without adequate financing and it is equally apparent that such adequate financing is impossible without the dues increase requested by the Board of Trustees. Your Reference Committee reaffirms its confidence in the judgment of the Board of Trustees which has in the past and must in the future exercise the most careful and prudent stewardship over the assets of the Association."

### Other Actions

In considering the 106 resolutions, 38 Board reports and at least 20 additional reports from councils and other groups, the House of Delegates also:

Strongly endorsed the *AMA Volunteer Physicians for Vietnam* program and urged that entire profession to support it by word and deed.

## LETTER TO THE EDITOR:

Bernard P. Wolff, M.D.  
Sheffield Building  
Atlanta, Georgia 30309  
June 27, 1966

Editor  
Journal of Medical Association of Georgia  
938 Peachtree Street N.E.  
Atlanta, Georgia

Dear Sir:

With the deluge of Medicare patients descending upon the hospitals and doctors, we physicians should take a long look at some of the hospital admission policies. To illustrate, a typical 300 bed hospital in Atlanta usually has statistics about as follows:

Total admission approximately 13,000. Surgical patients of all types, including general surgery, orthopedics, OB-GYN, ENT, and neurology, approximately 11,000 patients. Medical admissions approximately 2,000.

This same hospital will generally have an active attending staff comprised of at least 60 internists and 40 to 50 surgeons. Of the ill medical patients admitted to the hospital, practically every one is an emergency admission, but on breakdown of the figures it is startling to find that 30% of medical admissions occur for work-up examinations to be paid for by hospitalization insurance policies. It is at this tender point that the internist must search his conscience and make a judgment as to admission policy. If an individual has paid for health insurance and if he is entitled to hospitalization benefits with the help of the laboratory and x-ray or diagnostic procedures, it might be said that he certainly is entitled to reap the benefits of this policy. On the other hand, is the situation such that we are denying bed space to ill patients who should be in the hospital and who have life-threatening situations arise time and again when they cannot be admitted? Obviously, the latter is true.

Any internist who can limit his practice to one hospital is fortunate indeed, as it is practically impossible to obtain emergency beds even when one may belong to

Adopted a resolution urging constituent medical associations to oppose, as detrimental to the public interest, any proposed legislation that would authorize *optometrists* to engage in the diagnosis or treatment of disease or injury of the eye;

Agreed with a strong policy statement condemning the *abuse of LSD* and other non-narcotic drugs, pointing out that the illicit use of LSD is subverting and vitiating important and necessary valid experimental studies, and recommending that the manufacture and distribution of LSD be continued as needed under strict control, with the drug being made available only to competent research workers (physicians trained in its use) on approval of the Department of Health, Education and Welfare;

Reaffirmed its opposition to the compulsory regulation of any *single* method, such as the use of generic terms, of the *prescribing of drugs*.

and assume the responsibility of being an active member of three or four staffs.

No doubt, most internists have had experiences such as I—being unable to get a patient with a bleeding ulcer into the hospital, or a coronary in shock will be sent home from the hospital emergency room after an all night stay waiting to obtain a bed. These things are highly frustrating and infuriating and are patently a defect in our present medical practice.

What then, is the solution for this problem? Quite obviously we need more beds, more help and more staff. That goes without saying.

The insurance companies must allow the individual physician to perform complete work-ups in the office rather than insisting on hospitalization. Undoubtedly, there will be a few physicians who will take advantage of this program, but most will not. It would seem that the doctors should organize themselves into a concerted group and demand a more equitable arrangement from the insurance companies. I feel that the insurance companies have reached the point where they must put more faith, trust and leadership in the medical profession, rather than simply handing us a set of rules which we must follow.

All physicians admitting patients to the hospital should search their conscience deeply and rule out routine examinations in those who can afford to have them on an out-patient basis, even though they have hospitalization. I have done this time and again and in most instances the patient agrees, but there have been a few times when the patient has gone to another internist who has promptly put the patient in a hospital.

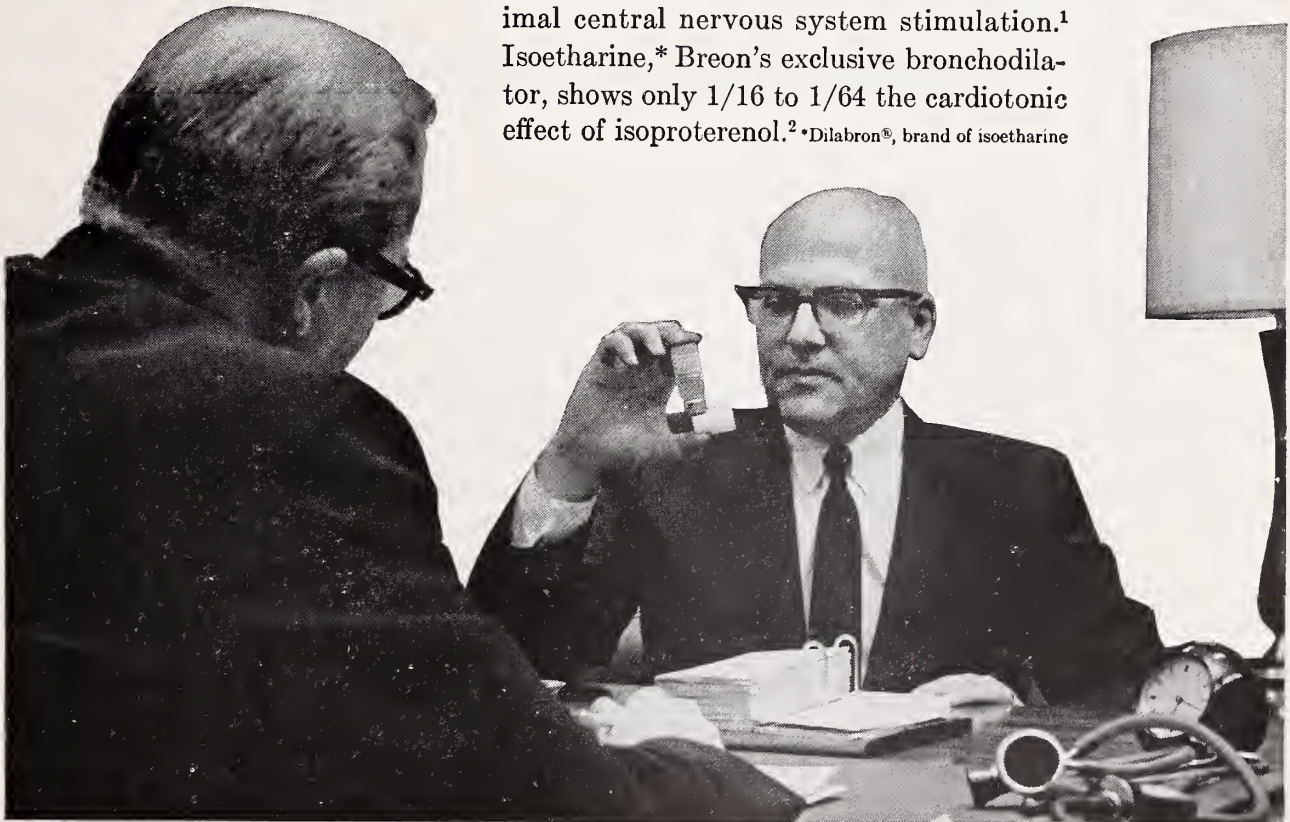
It might be wise to institute a committee which would review the admission practices of the staff, and if flagrant and repeated violations of trust in admitting patients for work-ups are found, then this physician should be warned that he might lose his staff privileges. This latter type of police action is very distasteful, but probably would be very successful in the same manner as the tissue committee was very successful in policing the operating room.

Very truly yours,  
Bernard P. Wolff, M.D.



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**PRECAUTIONS:** Bronkometer is unusually free from cardiovascular and other side effects, but the usual precautions associated with sympathomimetic amines should be observed. Bronkometer should not be administered simultaneously with epinephrine or similar compounds because of the possibility of tachycardia, although it may be alternated with these agents. Dosage must be carefully adjusted in patients with hyperthyroidism, hypertension, acute coronary disease, cardiac asthma, limited cardiac reserve and in individuals sensitive to sympathomimetic amines.

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## PRESIDENT'S LETTER

### THE AMA CONVENTION AT CHICAGO

**W**E HAVE JUST returned from the AMA Convention in Chicago. It was a most interesting and enlightening one from many aspects.

Your delegates, alternate delegates, officers and members who attended spent many hours of hard work in caring for the many problems and procedures which came before us and considering the many proposals which required study and action.

#### 105 Resolutions

There were approximately 105 resolutions to be presented to the House of Delegates. These were all reviewed by your delegation and divided among us to study and to appear in the proper reference committees for discussion and action.

The reference committee actions and recommendations were then reviewed and decisions made as to whether we would support or oppose these in the House of Delegates meeting.

Many proposals brought forth prolonged and spirited discussions in the delegates' meeting and there were several important changes made and reference committee proposals overridden—too many to enumerate here.

There were 10,400 doctors registered during the convention. There were 19,600 allied and associate and auxiliary registrations. This was a total of 30,000 plus for the entire meeting.

The inaugural ceremony installing Dr. Charles Hudson as President was very impressive. All of the 50 state presidents, officers and AMA board of trustees assembled beforehand and sat together on an elevated rostrum for this occasion. Dr. Hudson's acceptance address was most timely and appropriate,

reviewing past accomplishments, but primarily outlining his purposes and hopes for what may be done during his tenure of office and in years to come.

He stressed again the immediate new and multiple problems facing our profession and our continued efforts to resist further federal regulations encroaching on our established methods of practice and care for those requiring our help.

The scientific exhibits, including new diagnostic and treatment apparatus and methods, were most interesting and enlightening. Many new research projects and results were exhibited and outlined. New drugs and their uses were displayed and also discussed in the scientific meetings. These meetings and presentations were of the highest quality. Many outstanding doctors and members of our allied professions from all parts of the country took part in the scientific programs.

#### Too Early to Estimate

As I write, Medicare is now four days old and it is entirely too early for us to compile figures or to estimate the initial impact on our offices and hospitals. It will take time for the program to level out and stabilize. However, contact with our Savannah hospital admission offices has not found too much of a rush for admission of medicare patients through July 4; also, our offices have been open only two days and not a great difference has as yet been noted.

Walter Brown, M.D.

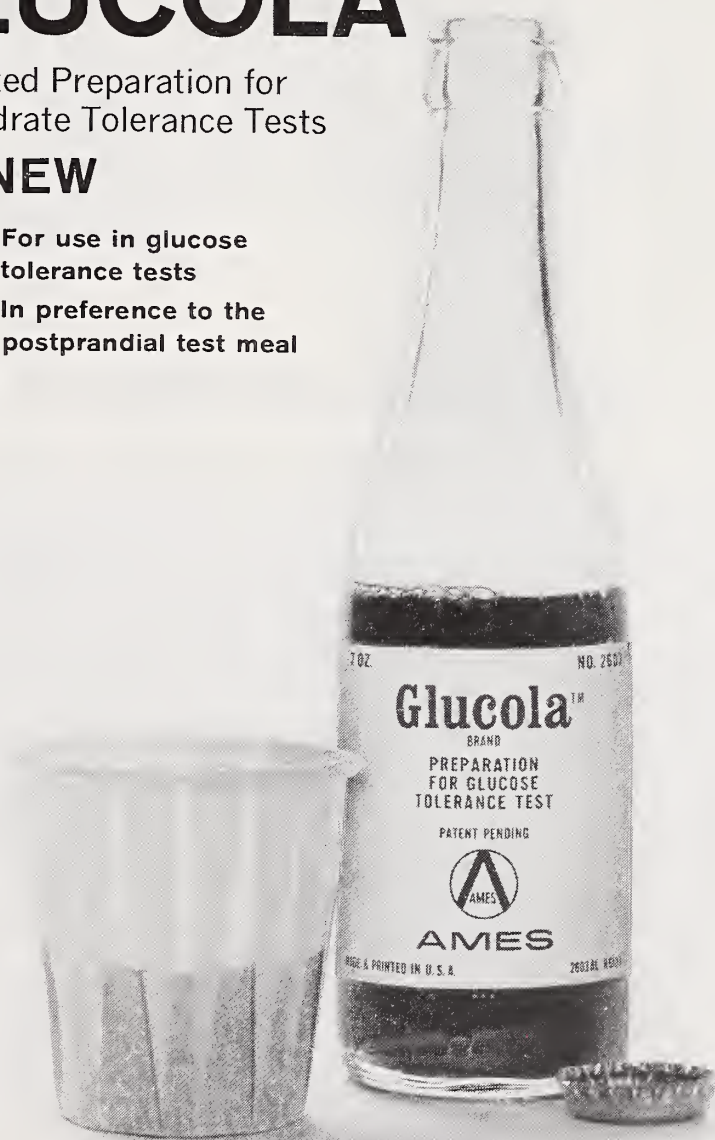


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## SYMPTOMATIC COARCTATION OF INFANCY

Dorothy Brinsfield, M.D., *Atlanta*

A CONstriction of varying length may occur anywhere along the aorta, but in 95% of cases it is a localized constriction just distal to the left subclavian artery. Coarctation of the aorta is twice as common in males as females and makes up about 5% to 10% of congenital heart defects. It is estimated that over half of the patients with coarctation discovered in childhood will have symptoms in the first year of life, usually between one week and three months of age. The infant may present with congestive failure but no significant murmur. The clinical picture includes poor weight gain, feeding difficulties, tachypnea and cough with rapid progression of the symptoms. Severe congestive failure and death may occur in such an infant with an uncomplicated coarctation. Many of these infants, however, have associated defects such as patent ductus arteriosus, ventricular septal defect, aortic stenosis, mitral stenosis, transposition of the great vessels, single ventricle, and endocardial fibroelastosis of the left side of the heart. The diagnosis can be made in the majority of cases by proper blood pressure determinations. This is frequently omitted in the critically ill infant but is a vital part of the examination. Coarctation should be strongly suspected when the femoral and dorsalis pedis arterial pulses are not palpable in the presence of easily palpable brachial arterial pulses. Jugular venous pressure may be elevated and the liver greatly enlarged. The heart is usually moderately enlarged with a sustained left parasternal impulse. A ventricular gallop and a systolic ejection click are frequently heard at the apex. If a patent duct is present, the shunt will be from the aorta to the pulmonary artery unless there is severe pulmonary vascular disease (Eisenmenger's

syndrome), and the only murmur audible may be that of a ductus.

Chest roentgenograms show moderate cardiomegaly and pulmonary edema. The left atrium is enlarged, but the pulmonary blood flow is normal in the absence of associated defects. Right ventricular hypertrophy is present on the precordial leads of the electrocardiogram until the age of six months when evidence of biventricular or left ventricular hypertrophy appears. The QRS mean axis is in normal range for an infant and secondary T wave changes are common. Retrograde aortography from the brachial artery will demonstrate the site of the coarctation and is a relatively safe procedure. If associated defects are suspected, right heart catheterization may be necessary.

Congestive failure may be sudden in onset and progress rapidly to a shock-like state and death. Prompt and vigorous treatment of congestive failure is imperative and should be considered a medical emergency. Rapid intravenous digitalization, oxygen, rotating tourniquets and positioning the patient in a pediatric cardiac chair are indicated. Improvement is usually seen within 12 to 24 hours after therapy is instituted. If improvement does not occur, diagnostic studies are indicated and emergency surgery should be considered. Infants who respond to medical treatment will usually improve over the next few months, although they may be retarded in their growth. After two years of age, patients are commonly asymptomatic, and surgery should be delayed until an optimal age of eight or more years.

*Emory University School of Medicine*

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



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The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

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Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg.



10 mg.



15 mg.

## DESBUTAL 10 Gradumet

10 mg. Methamphetamine Hydrochloride,  
60 mg. Pentobarbital Sodium



Front



Side

## DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,  
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Front



Side

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Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

## Desbutal 15 Gradumet

Product of choice for patients who overreact to plain amphetamine

**INDICATIONS:** As an anorectic in treatment of obesity, also to counteract anxiety and mild depression.  
**CONTRAINDICATIONS:** Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed; often these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals.

**DOSE:** A single Gradumet tablet in the morning provides all-day appetite control.  
**DESBUTAL 10:** Desbutal 10 contains 10 mg. of methamphetamine hydrochloride and 60 mg. of pentobarbital sodium. Desbutal 15 contains 15 mg. of methamphetamine hydrochloride and 90 mg. of pentobarbital sodium. In bottles of 100 and 500.

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A proven aid to weight control —

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—in tablets and liquid—

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For:

Directions:

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**CONTRAINDICATION:** Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

**PRECAUTIONS:** Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.



Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.  
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Frankly, most antihypertensives are pretty good if you give an adequate dose. I'm looking for one with a simple regimen so that mix-ups in doses and therefore the chance of side effects are minimized.



## Regroton®

chlorthalidone 50 mg, reserpine 0.25 mg.

1 tablet daily  
brings pressure down

**Advantage:** Both components of Regroton are long-acting.

**Average dosage:** One tablet daily with breakfast.

**Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.

**Warning:** Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.

**Precautions:** Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.

**Side effects:** Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness. For full details, see the complete prescribing information.

**Availability:** Bottles of 100 and 1000 tablets.

# Geigy





## MEDICINE, PSYCHIATRY, DIAGNOSIS AND HORSEFEATHERS

William E. Wood, M.D., *Augusta*

THROUGHOUT the history of medicine, diagnostic impression has been of primary concern. The approach to disease has been one of cause and effect relationship. An attempt to alleviate the cause in order to modify its possible detrimental effect has constituted the treatment regimen. Following the establishment of a diagnosis and institution of a therapeutic program, prognostic evaluation has been regarded as a necessary consideration. Consequently, diagnosis has been of utmost importance to the welfare of the patient and his family for two reasons: First, the institution of a plan of therapy in order to alter, if possible, the course of a disease process; and secondly, the calculation of future adaptivity so that adequate preparation for the consequential effect of that disease might be undertaken.

### Impression Abused

Again, throughout the history of medicine, the diagnostic impression has been abused. Diagnosis has inferred prognosis and has precluded the therapeutic regimen in many cases. The inevitable fatality of consumption and cancer are cited as merely two of numerous examples. With the advent of more modern methods, emphasis has been realistically redirected to the primary concern of treatment rather than the pessimistic secondary consideration of prognosis. Through willingness to research and to understand, the proper perspective has been achieved in many areas.

Psychiatric diagnosis, unlike that of other medical subspecialties, is a brief description of behavior,

rather than a specific disease entity, although the usual cause and effect relationship is evident after investigation is concluded. The diagnosis is one of maladaptive behavior presented at the time of diagnostic endeavor, and consequently, is not final since behavior is fluctuant.

### Diagnostic Dilemma

Fluctuations in behavior often lead to several diagnostic labels being placed upon the same patient, or to a diagnostic dilemma.

The tendency of associating pessimistic prognosis with psychiatric diagnosis often serves to damn the patient and causes him to be set aside as an incurable, undesirable component of society prior to the institution of a therapeutically oriented program designed to modify his maladaptive behavior. In following such a trend, a grave error in the continuity of the scientific approach to medicine is made. Diagnosis of functional problems has a minor place in psychiatry and to add undue emphasis on its establishment causes the continuation of archaic attitudes such as those associated with carcinoma and tuberculosis of former years. With behavior changes, not only from day to day, but from moment to moment and with proper modifying influences, patients can achieve adaptivity regardless of former behavioral patterns. Prognosis is not associated with diagnosis but with the efficacy of therapy.

*Talmadge Memorial Hospital*

Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.

## SOCIETY FOR CRYO-OPHTHALMOLOGY FORMED TO PROMOTE INVESTIGATIVE TECHNIQUES

The Society for Cryo-ophthalmology has been formed to promote investigative and clinical applications of low-temperature technics to the eye. Applications for membership will be welcomed from those interested in the investigative aspects of this subject, the preservation of ocular tissue, therapeutic applications of cryogenics to various ocular diseases, and cryosurgical technics. It is

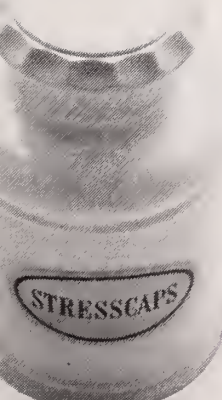
contemplated that scientific meetings will be held immediately prior to the annual sessions of the American Academy of Ophthalmology and Otolaryngology.

Inquiries and applications should be addressed to: Dr. John G. Bellows, 30 N. Michigan Blvd., Chicago, 60602.



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## ABSTRACTS BY GEORGIA AUTHORS

Jello, Gloria, M.D.; Hill, Justina, M.D., and Ambrose, Samuel, M.D., *Ferst Research Center, Piedmont Hospital, Atlanta, Ga. 30309*, "Rapid Presumptive Identification of Gram-Negative Bacteria in Urinary Sediments of Immunofluorescent Technics," *Investigative Biology* 3:486-497(March)1966.

The feasibility of detecting and identifying nine serogroups of *E. coli* (1, 2, 3, 6, 7, 11, 15, 62, 75) in washed urinary sediments by the use of pooled and monovalent fluorescent antibodies was demonstrated. With these nine conjugates, it was possible to detect *E. coli* in approximately 1/4 of the 100 urine specimens tested and to serogroup 48% of 140 *E. coli* cultures isolated from cases of urinary infection. Cultures belonged to a total of 38 different O groups, not counting rough and ungroupable strains. The use of conjugates covering a larger number of O groups would make possible the identification of *E. coli* in a higher percentage of cases.

Fogler, W. R., M.D.; Bain, J. R., Ph.D.; Hugley, C. M., Jr., M.D.; Palmer, H. G., Jr., M.D., and Lowrey, M. E., M.D., *Dept. of Medicine, Emory Univ. School of Medicine, Atlanta, Ga.*, "Metabolic and Therapeutic Effects of Allopurinol in Patients With Leukemia and Gout," *The American Journal of Medicine* 40:548-559(April)1966.

Allopurinol ("Zyloprim," Burroughs Wellcome) has been shown to prevent the formation of uric acid resulting in decreased excretion of uric acid and an increase of the intermediate purines, xanthine and hypoxanthine, by inhibition of xanthine oxidase. Six-mercaptopurine ("Purinethol," Burroughs Wellcome) is normally catabolized in a similar manner with an increase in thiouric acid excretion. Allopurinol has been shown to decrease the dose necessary for therapeutic effect in patients with chronic granulocytic leukemia.

Nine patients—seven with acute leukemia, one with acute lymphoblastic lymphoma and one with chronic myelocytic leukemia—received 6-mercaptopurine and allopurinol. The urinary excretion of 6-mercaptopurine was increased from less than 3% to as much as 27% of the administered dose. There was a striking fall in uric acid excretion in all patients with a concomitant rise in urinary oxypurines coincident with a fall in leukocyte count. One of seven patients with acute leukemia refractory to 6-mercaptopurine alone achieved a complete remission of short duration on the combination of 6-mercaptopurine and allopurinol.

In seven patients with gout there was a marked fall in serum uric acid concentration and urinary excretion of uric acid with a rise in oxypurines after the administration of allopurinol. Doses ranged from 400 to 1,000 mg. daily. There was no renal, hepatic or hematologic toxicity though attributable to allopurinol.

Allopurinol is a major therapeutic advance in the management of patients with gout and in the hyperuricemia seen in acute leukemia. An increased chemotherapeutic effect when combined with 6-mercaptopurine remains unanswered.

Berry, J. Norman, M.D., *Dept. of Medicine, Piedmont Hospital and Emory Univ. School of Medicine, Atlanta, Ga.*, "Epilepsy Precipitated by Abrupt Meprobamate Withdrawal," *Southern Medical Journal* 59:592 and 600(May)1966.

A thirty-six-year old woman had three grand mal seizures 30 hours after abruptly discontinuing meprobamate, which she had taken in a dosage of 1.2 grams daily for 20 days. There had been no previous seizures except for eclamptic convulsions ten years before. Abnormal EEG's and subsequent seizures following minor surgery under intravenous barbiturate anesthesia substantiated the impression of idiopathic epilepsy. By inference it is thought that individuals who give any history of convulsions, and whether or not they are believed to be true epileptics, should be carefully screened before being given meprobamate and similar drugs. If then given (even in "standard" dosages), gradual rather than abrupt withdrawal might prevent the recurrence of seizures.

Tanner, James C., Jr., M.D.; Vandeput, Jacques J., M.D., and Bradley, Wm. H., B.S., *Atlanta Research Institute and the Dept. of Surgery, Crawford W. Long Memorial Hospital, Atlanta, Ga.*, "Two Years With Mesh Skin Grafting," *The American Journal of Surgery* 111:543-547(April)1966.

Recognizing the need for more efficient use of available donor skin, the authors devised an expanding skin graft called the "Mesh Skin Graft." It has the advantages of the sieve graft and modified sieve graft plus 300% expansion and has been used clinically since July, 1963. This paper presents results, indications for its use other than for burns, and details of improvements in equipment and methods of application from experience gained in 250 clinical cases.

Information obtained from these cases indicated the following:

1. The mesh graft is of most value in covering large skin defects on patients with insufficient donor areas.
2. Wounds with excessive discharge are covered more easily with mesh grafts.
3. Open postoperative care should not be used.
4. The healed mesh graft is cosmetically inferior to sheet grafts; however, it is satisfactory and is cosmetically superior to postage stamp grafts.
5. Skin coverage is facilitated by simultaneous debridement and grafting or delayed application of stored autografts.
6. Less donor area is required.
7. The mesh graft is very adaptable.

8. The use of glue and adhesive strips is advantageous in many cases.

Chelton, L. Guy, M.D., and Whisnant, Charles L., M.D., *41 Peachtree Place, N.E., Atlanta, Ga. 30309*, "The Combination of Alcohol and Drug Intoxication," *Southern Medical Journal* 59:393(April).

One hundred consecutive alcoholic patients admitted to Peachtree Hospital, Atlanta, Georgia, were screened for Barbiturates, Meprobamates, and Phenothiazines. A simple, rapid and relatively inexpensive procedure using Thin Layer Chromatography was employed. Thirty-eight per cent were found to have been taking one or more of these drugs, although only nine per cent admitted this. This study emphasizes the fact that many of these patients were withdrawing from drugs as well as alcohol. This finding should be utilized in their therapy. It is also noted that there was less tendency to misuse Phenothiazines in this group of patients.

Talledo, Eduardo, M.D.; Carter, W. F., M.D.; Burns, W. L., M.D., and Zupan, F. P., M.D., *Dept. of OB-GYN, Medical College of Georgia, Augusta, Ga.*, "Opacification of the Amniotic Fluid for Localization of the Placenta," *Southern Medical Journal* 59:581-584(May)1966.

Amniography was performed in 32 patients for various clinical indications: in 19 for the sole purpose of placental localization, in eight for the diagnosis of fetal life, in two for multiple pregnancy, in two for Rh incompatibility and in one for polyhydramnios. The placental site was localized in 31 out of 32 patients. Premature labor was not encountered in viable pregnancies. In six out of eight patients with fetal death in utero, delivery occurred within 54 hours from the procedure. It is concluded that amniography is a practical and valuable tool in well selected cases.

Folger, Gordon M., Jr., M.D., *Dept. of Pediatrics, Medical College of Georgia, Augusta, Ga.*, "Suppurative Pericarditis," *Clinical Pediatrics* 5:225-229(April)1966.

Two patients with suppurative pericarditis due to systemic staphylococcal infection are described. One of the patients, aged 21 months, died shortly following admission to the hospital of staphylococcal septicemia. The other patient, aged 9 1/2 years, first developed a cutaneous staphylococcal infection followed by osteomyelitis and pericarditis. Initially managed medically, he subsequently underwent pericardectomy following definite diagnostic studies. In addition to the routine diagnosis and management of purulent pericarditis, due to staphylococcus, the more recent and definitive laboratory methods are described and discussed. In the one living case, evidence is presented for progression to an adhesive pericarditis, suggesting further advance to the constrictive form of the disease. The methods



of treatment are presented and briefly discussed.

**Parrish, R. A., Jr., M.D.; Sherman, H. S., M.D., and Moretz, W. H., M.D., Dept. of Surgery, Medical College of Georgia, Augusta, Ga., "Congenital Antral Membrane," Surgery 59: 681-684(May)1966.**

The first case of prepyloric membrane or septum in an adult was reported by Sames in 1949. Since this time only seven cases of congenital antral membrane have been reported and one further case is described in this report. Although there have been two cases of antral membrane reported in the newborn, the condition apparently is seen most commonly in middle age. The most constant finding in these cases is nausea and vomiting occurring shortly after ingestion of food. The remainder of symptoms such as epigastric pain, anorexia, weight loss, and temporary relief from ingestion of antacids, are highly variable and offer little help in differential diagnosis. The roentgenographic appearance on barium study of the stomach is remarkably similar in all recorded cases. The antral septum is usually a thin, constant, knife-like filling defect approximately two cm. from the pylorus, with barium passing beyond the defect and filling the distal antrum, pylorus, and duodenum. The delay in emptying of the barium filled stomach has been variable, but in no case has there been evidence of complete obstruction. The constant gross and microscopic findings in all of the cases reported should leave no doubt that this is a congenital anomaly. The lesion probably represents a failure of complete revacuolization of the gastrointestinal tract during embryonic development. The absence of fibrosis and the lack of any direct relationship to peptic ulceration would make unreasonable the possibility of the septum being acquired. The late onset of acute symptoms in these cases is probably due to the generalized decrease in gastric tone found with advancing age. When this antral membrane is recognized at surgery as merely a congenital deformity, without associated peptic disease, the treatment of choice is simple excision.

**Hatcher, Charles R., Jr., M.D.; Logan, Wm. D., Jr., M.D., and Abbott, Osler A., M.D., Div. of Thoracic and Cardiovascular Surgery, Emory Univ. School of Medicine, Atlanta, Ga., "The Management of Acute Airway Problems in Infancy and Childhood," Diseases of the Chest 49:516-521(May)1966.**

The maintenance of a patent airway and satisfactory tracheobronchobronchial toilet is a vital part of the management of many types of pediatric disorders. Congenital defects, foreign body aspiration, trauma, acute inflammatory processes, and certain neurological diseases may all produce inadequate ventilation through a variety of mechanisms. This report concerns the experience with such problems at The Henrietta Eggleston Hospital for Children. Included in this report are the details of 50 cases which have required tracheostomy in the past three years. A technique for atraumatic and effective endotracheal suctioning at the bedside is

described. This technique utilizes exposure of vocal cords by elevation of the base of the tongue with a laryngoscope and insertion into the trachea of a soft rubber tipped suction device. Certain valuable maneuvers employed to permit diagnostic and therapeutic bronchoscopy without the necessity of tracheostomy are described. The indications, surgical technique, postoperative management, and complications of tracheostomy are discussed. Emphasis is placed on the essential safety factor obtained by preliminary insertion of an endotracheal tube or bronchoscope and subsequent performance of tracheostomy with such an airway tube in place. The details of management designed to prevent acute respiratory catastrophe and reduce later complications (such as infection or stricture) are presented. A systematic approach for the removal of the tracheostomy tube from the infant is outlined. Comments are made on the indications for, technical aspects, values, and dangers of mechanical respirators and ventilators. Technical competence, a thorough knowledge of respiratory physiology, and careful attention to detail will permit the surgeon to employ tracheostomy more liberally as a useful adjunct to therapy in pediatric practice.

**Bridges, Wm. Z., M.D., Department of Physiology and Ophthalmology, Emory Univ. School of Medicine, Atlanta, Ga., "Electroretinographic Manifestations of Hyperbaric Oxygen," Archives of Ophthalmology 75: 812-817(June)1966.**

The survival and characteristics of the electroretinographic activity during hyperoxia were studied in rabbits exposed to 2.5 to 7 atm of oxygen. The a- and b-wave were correlated with the duration and pressure of oxygen exposure. The results indicate the a-wave persisted longer than the b-wave; however, the survival of both waves was pressure dependent. The ratio of the a-wave to the b-wave survival time increased from 1.4 to 2.8 in the pressure range used. Within 15 minutes after the pressure of oxygen was increased, an enhancement occurred in both the a-wave and the b-wave. The duration, slope of rise, and maximum of enhancement were pressure dependent. The time constant of decline of the b-wave following maximal enhancement was shorter than that of the a-wave. These data show an early and biphasic manifestation of hyperoxia on the electroretinogram.

**Fite, J. Donald, M.D. and Lewis, Allen D., Emory Univ. School of Medicine, Atlanta, Ga. 30322, "Familial Anomaly Simulating Papilledema: A Case Report," The Journal of Pediatrics 68:927-931(June)1966.**

The case of a child with a familial anomalous hyperemia of the optic disk simulating early papilledema is presented. Idiopathic diabetes insipidus and headaches were also present. When one is confronted by a patient whose ocular findings suggest papilledema, frequent observation of his fundi over an extended period as well as examinations of other members of the family may help determine whether this is true papilledema, or a familial anomaly such as hyperemia of the disk.

**Roberts, Sava, M.D. and Hamilton, Walt M.D., VA Hospital, Augusta, Ga., "Regional Enteritis of the Duodenum," Radiology 88:1-885(May)1966.**

The authors present seven cases of regional enteritis of the duodenum. Surgery was performed on six of the cases. Three of these were confirmed by biopsy and three by inspection and palpation at the time of surgery. One case was not proven.

The most common subjective and objective findings noted in these cases were epigastric pain, nausea, vomiting, fever, microcytic anemia, and weight loss of varying degree. No abdominal masses were palpable; nor was the diarrhea, macrocytic anemia or external fistulae. In one case an internal fistula was found at surgery with serous transudate around the duodenum; culture and cell block were negative. In two cases there was roentgen evidence of duodenal ulcers. In only one of these was an ulcer found at the time of surgery; this lacked microscopic findings characteristic of peptic ulcer. Two patients had involvement of the antrum of the stomach and the mid-jejunum.

Roentgenic findings, among others, consisted of a smooth "string" sign, deviation in the size of the lumen which may be dilated or narrowed, areas of maximum stenosis, and variations in the mucosal appearance.

At surgery most of the cases presented induration, edema and thickening of the walls of the involved segment of the duodenal loop with enlargement of the adjacent nodes. Mesenteric thickening was also noted in some cases.

The authors state that the changes vary considerably from enteritis of the ileum and jejunum, probably because we are seeing the pathology earlier in this area than we do in the distal small intestine. Severe ulcerative changes are seldom encountered, according to the article. It is their opinion that spontaneous regression apparently does occur but with incomplete resolution. Anatomic variations, according to the article, in the distribution of the regional lymphatics may be a factor in the difference between the findings in the duodenum and elsewhere in the small intestine.

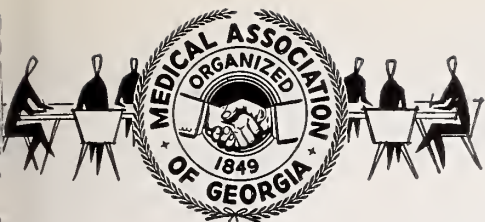
**Killam, H. A. W., M.D.; Crowder, J. C., M.D. White, A. C., M.D., and Emonds, J. H., Jr., M.D., Dept. of Medicine, Medical College of Georgia, Augusta, Ga., "Pericarditis Due to *Vibrio Fetus*," The American Journal of Cardiology 17:723-728(May)1966.**

A case of *Vibrio Fetus* infection is reported in which pericarditis was the presenting finding, and *Vibrio Fetus* was isolated from cultures of pericardial fluid and blood.

*Vibrio Fetus* infections in cattle have been recognized since 1909 and presently represent a leading cause of economic loss to the farmer. Reports of *Vibrio Fetus* infections in man have appeared only recently, and to date 2 cases have been reported.

Data from this patient and other reported cases are discussed. The patient's progressive downhill course prior to antibiotic therapy and the persisting neurologic damage emphasize the need for early diagnosis and proper management in this very serious infection.





# THE ASSOCIATION

## DEATHS

**William Barron Crawford, Jr.**, 58, of Savannah died May 25, 1966, after a short illness.

A native of Savannah, he was a graduate of Woodberry Forest Preparatory School in Virginia, Princeton University and Columbia College of Physicians and Surgeons. He served three years overseas as a major in field hospital in World War II and was decorated for bravery. He was a member of the Hibernian Society, the St. Andrews Society, the Oglethorpe Club and the Century Club.

Dr. Crawford twice was elected president of the staff of St. Joseph's Hospital. He was the son of Dr. W. B. Crawford, who was president of St. Joseph's staff for 19 years.

Surviving are his wife, Mrs. Virginia McMichael Crawford; a son, William B. Crawford III of Columbus; a daughter, Mrs. John Fishburne, Jr. of Homestead, Fla.; two sisters, Mrs. Patty Gaillard of Savannah and Mrs. Belknap Bourne of Asheville, N.C., and two grandchildren.

**Henry Clifford Ellis**, 84-year-old McDonough and Henry County physician, died June 11, 1966, after an extended illness. Dr. Ellis had practiced medicine in Henry County and surrounding communities for 55 years.

He was educated in the Spalding and Henry County Schools, Locust Grove Institute, and graduated from the Atlanta College of Medicine, now Emory University School of Medicine, as president of the senior class of 1906.

Dr. Ellis served on the McDonough City Council; as chief surgeon for the Southern Railway for 28 years; president of the Henry County Medical Society. He was a member of the Medical Association of Georgia and the American Medical Association. He was awarded an honorary life membership in MAG in 1951. He served on the staff of the Griffin-Spalding County Hospital for several years and as Henry County physician for many years. He was a Mason and a member of the First Baptist Church of McDonough.

Dr. Ellis is survived by his wife, the former Willie McDowell; two daughters, Mrs. Ben B. Carmichael and Mrs. J. Stewart Taylor, both of McDonough; three granddaughters, Miss Jeane Carmichael and Misses Myse and Claire Taylor, and one grandson, Dr. Benjamin Macklin Carmichael of Walter Reed Army Medical Center, Washington, D. C.; a sister, Mrs. T. O. McDonald of Albany, Ga., and several nieces and nephews.

**Glenville Arkwright Giddings**, 45, of Atlanta died June 9, 1966, at his home.

A graduate of Emory University and Emory Medical School, Dr. Giddings was a former president of the Emory chapter of Chi Phi fraternity, a member of Phi Chi Medical Fraternity, the Medical Association of Georgia, the Atlanta Medical Society and Northside

Methodist Church. He was a World War II veteran of the Navy Medical Corps and had practiced medicine in Atlanta since the war.

Survivors include two daughters, Miss Dorothy Arkwright Giddings and Miss Alexa Calay Giddings, both of St. Louis; mother, Mrs. Glenville Giddings, Atlanta, and a sister, Mrs. Matthew Conner, Atlanta.

**Benjamin Goldman** of Hazelhurst died June 5, 1966, in Hollywood, Florida.

He is survived by his wife, Mrs. Katye Goldman; two sons, Ronald of Winston-Salem, N.C. and Bruce of Plantation (Fort Lauderdale), Fla.; three brothers, Dr. Lewis Goldman, Murray Goldman, Harry Goldman; two sisters, Mrs. Samuel Stnoep, Mrs. Herbert Frank, all of New York City, and three grandchildren.

Dr. Goldman was born Dec. 27, 1908, in Queens County, New York City. He attended New York University, University of Alabama and Rush Medical School of the University of Chicago. He received his B.S. from NYU and his M.D. from Rush. His internship was taken at Morrisania City Hospital in 1935-37, and he received his license to practice medicine in 1936. He then came to Georgia and received the Georgia State license in 1937.

The Hazelhurst doctor was a member of Kiwanis Club, American Medical Association, Ware County Medical Society, Ocmaha Golf Club; he was for some time chief of staff of Clyde Duncan Memorial Hospital, and railroad surgeon for the Southern and G&F railways; he was a Shriner and Scottish Rite Mason and was an Elk. Dr. Goldman was a member of B'nai Brith and a member of the Fitzgerald Hebrew Congregation.

**Homer Scott Titshaw, Sr.**, Gainesville, died June 14, 1966, after a short illness.

Dr. Titshaw was an alumnus of the University of Georgia, Emory University and did graduate work in surgery at Columbia University, New York. While at Emory University he was a member of Alpha Kappa Kappa, an honorary fraternity for outstanding English students.

A veteran of World War I, Dr. Titshaw enlisted in New York City and served in the U.S. Army Medical Corps at Walter Reed Hospital where he was honorably discharged.

He was a member of the First Methodist Church where he served on the Board of Stewards.

Dr. Titshaw was active in civic affairs as a member of the Hall County Medical Society, the Lions Club, the Paul E. Bolding American Legion Post, the Medical Association of Georgia, and the Southern Medical Association. He served as chairman of the committee that organized and established Lyman Hall School.

In 1952 Dr. Titshaw was awarded the Cross of Military Service by the Georgia Division of the United Daughters of the Confederacy.

He was married to the former Nannie Maude Hartley of Barnesville.



THE ASSOCIATION / Continued

Survivors include three daughters, Mrs. Rubye Payne, Clarkston; Mrs. J. Carl Thompson, Avondale Estates; Mrs. Thomas Bobbitt, Dublin; a son, H. Scott Titshaw, Jr., Atlanta; two sisters, Mrs. J. Ross Apperson and Miss Mayrell Cronic, both of Gainesville; a brother, William Harrison Cronic, Gainesville; a sister-in-law, Mrs. Ernest P. Titshaw, Atlanta; 11 grandchildren and four great-grandchildren; a niece, Mrs. William D. Harrison, St. Louis, Mo.; a nephew, Harrison P. Cronic, Gainesville.

**Guy O. Whelchel, Sr.**, Athens physician for half a century, died at his home June 24, 1966. He was 77 years of age.

Dr. Whelchel had received several honors in recognition of and appreciation for his many years of unselfish service to people in the Athens area.

The Athens Rotary Club named him citizen of the month for March and the Crawford Long Medical Society presented him a bronze plaque in November, 1964, for his outstanding service.

He was valedictorian of the 1908 graduating class of the University of Georgia and received his medical training at the Atlanta College of Physicians and Surgeons in 1912.

Dr. Whelchel taught part time at the Medical College of Georgia until World War I interrupted his career. After service in the Navy, he practiced medicine in Comer with his father and brother.

In 1924, he came to Athens and was a member of the staff of Athens General and St. Mary's Hospitals, serving several terms as chief of staff. He brought the first clinical laboratory to this area and was instrumental in securing pasteurization of milk for this section.

In addition to his wife, Mrs. Ruth Cofer Whelchel, he is survived by one daughter, Mrs. Ruth Washington, Athens; two sons, Guy O. Whelchel, Jr., Hartford, Conn. and Dr. Merritt Whelchel, an Augusta eye specialist.

He is also survived by one sister, Mrs. Hubert McWhorter of Hapeville; a brother, C. C. Whelchel of California; eight grandchildren and a number of nieces and nephews.

COUNTY MEDICAL SOCIETIES

**Grady County Medical Society** has elected as its new President, S. L. Hancock of Cairo. W. J. Morton also of Cairo will serve as Secretary-Treasurer.

GCMS has had several interesting guest speakers for programs this year: Charles Watt, M.D., Thomasville; Bob Roberts, M.D., Pavo; and C. H. Hodges, Jr., M.D. of Thomasville. In June a film was shown by a representative from Pfizer & Co., Inc.

SPECIALITY SOCIETIES

The **Georgia Heart Association** has announced the following slate of officers for 1966-67:

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*Vice President*  
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*Treasurer*  
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Atlanta, Georgia 30327

*Past President*  
Dr. Louis L. Battey                1021 Fifteenth Street  
Augusta, Georgia 30901

PERSONALS

First District

**Lawrence Lee**, Savannah, has been elected Chairman of a community Health Council set up to coordinate efforts among existing health agencies and organizations and to promote health education. Dr. Lee headed a United Community Services Committee to study the need for such a council. The council will operate with the UCS Social Planning Division.

Second District

**Joe M. Turner**, Tifton heart specialist, spoke at the annual meeting of the Ware County Heart Association May 31, 1966.

Cairo physician, **Martin Bailey**, has been appointed to the State Board of Medical Examiners.

Fourth District

Approximately 500 persons paid tribute May 29, 1966, to **J. A. Johnson** who has practiced medicine in Manchester more than 50 years. The reception was planned by persons who were delivered as infants by the doctor. Dr. Johnson's three sons have become doctors; one of them, Edward G. Johnson, M.D. of Chattanooga, Tenn., was present for the occasion.

Fifth District

**Warren S. Dorough**, Atlanta surgeon, has accepted appointment as Director of the State Health Department's recently created Branch of Certification and Licensure.

Announcement of Dr. Dorough's appointment—effective June 1—was made by Dr. John H. Venable, director of the Georgia Department of Public Health. Dr. Venable said the unit Dr. Dorough will head has been created April 1 to administer the Department's new Medicare responsibilities, in addition to previously established departmental licensing functions.



Dr. Dorough, a native Georgian, has been in private practice in Atlanta for many years and has since 1951 served as Chief of Staff and Chief of Surgery of Georgia Baptist Hospital. Since January of 1965 he has also acted as medical consultant to the State Department of Family and Children Services.

**Robert M. Fine**, Decatur, attended the meetings of the Society for Investigative Dermatology and the AMA Convention held in Chicago, June 26-29, 1966.

**John Ransom Lewis**, Atlanta surgeon, spoke to the Dixie Council of Authors and Journalists at their dinner held June 17, 1966, at Brunswick.

Dr. Lewis is the author of several medical articles, many poems and a medical book, *Surgery of Scars*. He is currently working on another volume of poetry and a medical book concerning the basic principles of plastic surgery.

He has lectured in Europe on scar surgery and in his spare time is poetry editor of the *Georgia* magazine.

Dr. Lewis' topic was "Poetry Is Where You Find It."

**Bruce Logue** recently addressed the meetings of the Seaboard Medical Association in Nags Head, N.C. The titles of his talks were "Reassessment of Current Therapy of Myocardial Infarction," and "Pericarditis, A Commonly Missed Disease."

Dr. Logue recently was guest lecturer at the meetings of the Tidewater Heart Association in Virginia Beach, Virginia.

The Emory University Clinic Building has been named the **J. Elliott Scarborough** Memorial Building, memorializing the late Dr. Scarborough, longtime director of the Emory University Clinic. The action was taken by the executive committee of Emory's board of trustees at a recent meeting.

**Lester Rumble, Jr.** was guest speaker at a seminar presented by the Ohio Valley Chapter of the American Association of Inhalation Therapists held at the Good Samaritan Hospital in Dayton on June 11 and 12.

Dr. Rumble also attended the American College of Chest Physicians meeting in Chicago, June 25-27. He received his certificate of Fellowship at the convocation.

#### Sixth District

**A. C. Martinez**, Milledgeville, attended an intensive post-doctoral course, "Basic Science and Its Relation to Cardiovascular Disease," in Boston in June. The course was offered under the auspices of Courses for Graduates, Harvard Medical School.

**W. P. Downey** has announced the closing of his medical office in Tallapoosa. Dr. Downey has practiced in Tallapoosa since 1905.

**Malcolm Williams** of Smyrna has announced the association in partnership with him of **Bernard Strickman**. Dr. Strickman comes to Smyrna from Los Angeles, Calif.

#### Eighth District

Waycross gynecologist, **Edward B. Brown**, has been named a certified diplomate of the American Board of Obstetrics and Gynecology.

#### Ninth District

**W. Bruce Schaefer** of Toccoa has recently been elected President of the Association County Commissioners of Georgia.

**Alex B. Russell** of Winder was elected President of the Georgia State Board of Medical Examiners at the annual June meeting held in Atlanta.

#### Tenth District

The Augusta College Alumni Association named **Harold Engler** of the Medical College of Georgia as Alumnus of the Year in May. Dr. Engler, an Associate Professor of Surgery, was presented an inscribed plaque before 200 alumni and friends at the association's annual dinner in Augusta.

## DISACCHARIDE FREE FORMULA MENTIONED IN THE SCIENTIFIC ARTICLE ENTITLED, "CHRONIC DIARRHEA IN INFANCY WITH RESULTANT DISACCHARIDE MALABSORPTION"

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**Allergy to Insect Stings**  
See pages 373 and 391



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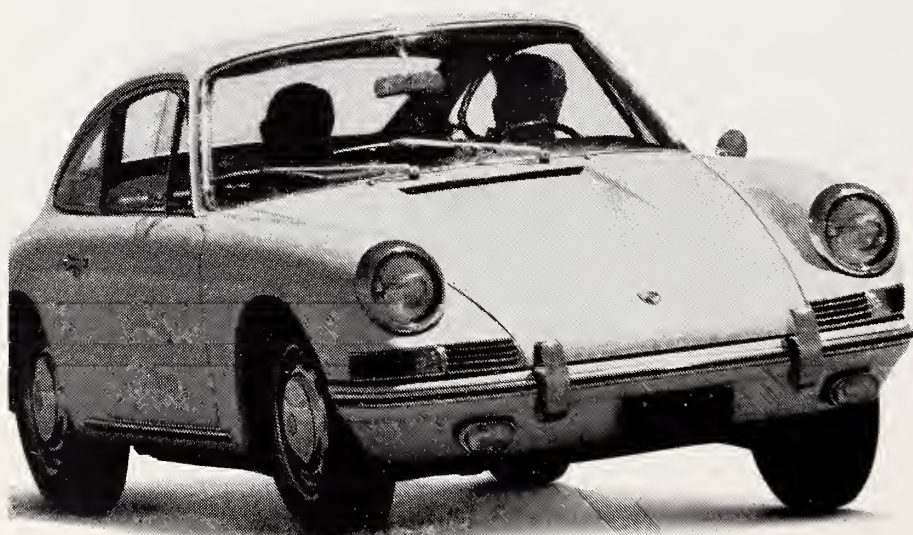
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Cover

*Polistes annularis* (Wasp). Illustration courtesy of Hollister Stier Laboratories, Inc., Los Angeles, California.



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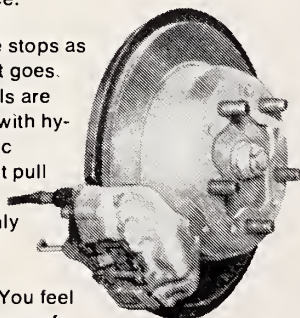
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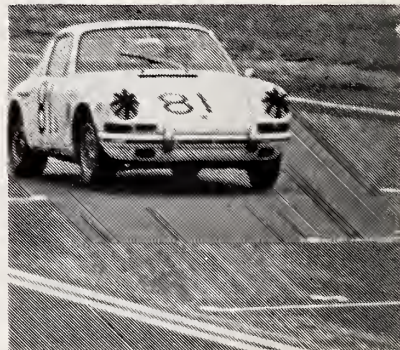
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# REACTION TO HYMENOPTERA INSECT STINGS

Walter McEarchern, M.D., *San Antonio, Texas*

- Hyposensitization constitutes the most effective defense against these reactions.

IT IS THE INTENDED PURPOSE of this paper to discuss the reactions incurred in humans as the result of stings inflicted by Hymenoptera insects.

## History

The earliest record of death from an insect sting is contained in the hieroglyphics found at the tomb of King Menes of Egypt, who probably was stung to death by a wasp or hornet in 2641 B.C. In 1765, Desbrest described a fatality from a bee sting above the eyebrow. Delaistre, in 1776, reported a death from a hornet sting in the palate. The first report in the American literature likely was by Mease, who in 1811 described a man who was stung in the nasal septum by a bee and died 30 minutes later.<sup>28</sup>

## Incidence

It is of interest to note that during a ten year period ending in 1959, 50% of all deaths from venomous animals in the United States were caused by the stings of insects. Poisonous snakes accounted for 138 deaths, while stinging insects caused 299 deaths. Of these 299 fatalities, bees killed 124 persons, wasps 69, yellow jackets 22, and hornets 10.<sup>16</sup> In addition, it is speculated that there are many deaths from insect stings that are incorrectly ascribed to heat prostration, myocardial infarction, or causes unknown.

## Identification

The Hymenoptera order of the class Insecta has two families: 1) Apids and 2) Vespids. Of the Apid family, the honeybee and the bumble bee are most important. The bumble bee, a rare offender, stings only when provoked and usually is involved only in cases of single bee stings. The honeybee also stings only when provoked, but may be involved in cases

of multiple stings. If the security of the bee hive, which may harbor as many as 50,000 bees, is endangered, honeybees will sting viciously in groups. The honeybee is the only stinging insect which has a stinging mechanism so constructed with barbs that the process of stinging inflicts self evisceration and death of the insect within 15 minutes.<sup>11</sup>

## Characteristics

Members of the Apid family are recognized easily by everyone, whereas Vespids are a source of confusion. There are at least 12 species of Vespids in most geographical areas of the United States, of which only three are very important: 1) Polistes (paper wasp), 2) hornet and 3) yellow jacket. Polistes, largest of the three species builds his small open-comb nest under eaves or on rafters in protected places. He stings only on provocation. The hornet constructs large oval papier maché type nests hanging from trees or shrubs. These nests may hold as many as 10,000 hornets which stream out at the slightest interference to attack viciously in large numbers. The yellow jacket, smaller but closely resembling the hornet, builds his nest near the ground or on the ground, under logs or in holes in the ground. Yellow jackets are most frequently provoked during the process of mowing the lawn. Consideration of these characteristics is helpful in identifying the offending insect in cases where positive identification is lacking.<sup>11</sup>

## Venom

### Chemical

The nature, both chemical and antigenic, of Hymenoptera insect venom has been the subject of much investigation for many years. Previously there has been a general conception that the local and



systemic reactions from stings were due to formic acid. More recent authors, e.g. Perlman et al<sup>26</sup> have held that formic acid is present in venom, but only in very small amounts and probably accounts for little, if any, of the toxicity or allergic reactions seen in Hymenoptera insect stings. Some investigators have felt they demonstrated three active venom components: 1) a hemolysin, probably phosphatidase, 2) a neurotoxin, which causes edema and paralysis and 3) a histamine-like substance which causes primary inflammation.<sup>13</sup> Several potent pharmacological substances in venom of Hymenoptera have been demonstrated by various authorities, including histamine, serotonin, and bradykinin. The enzymes hyaluronidase and lecithinase have been demonstrated in venom of all Hymenoptera, and cholinesterase has been demonstrated in wasp venom.<sup>3</sup> From wasp venom Holstock isolated 5-hydroxy tryptamine, hyaluronidase, histamine, and kinin, a polypeptide with demonstrated ability to constrict smooth muscle and lower blood pressure without mediation through histamine release. Holstock felt that kinin could account for local pain and edema, but not for the more severe systemic reactions to insect stings.<sup>10</sup>

### *Antigenic*

Exhaustive studies have been made on the antigenic nature of Hymenoptera insect venom. There has been much discussion and speculation about antigens specific to the venom of bees, yellow jackets, wasps, and hornets and antigens common to these insects. Langlois et al<sup>4</sup> have demonstrated specific antibodies in the sera of patients sensitive to stinging insects. In their studies, two groups of sensitive patients were evident: one group reacted to two or three different types of insects, whereas the other group reacted to only one type of insect. These differences were explained by three hypotheses: 1) the group with cross-reactions to several insects may have been stung by more than one type, thereby stimulating the formation of a variety of antibodies or 2) repeated contacts with one type of stinging insect may have sensitized the patient not only to species specific antigens (thought to be located in the venom) but also to antigens common to the genus (thought to be in the body), or 3) certain individuals may form antibodies against venom specific antigens only, whereas others may produce antibodies against both the specific and common antigens.<sup>4</sup> For further study, Langlois et al prepared extracts of venom sacs from the insects bee, wasp, and yellow jacket and studied these extracts for antigen content. These venom sac extracts were compared to sacless body extracts of the same insects to determine

the existence of antigens specific to the venom and antigens common to the body and venom of these insects. They were able to demonstrate at least one and probably two antigens specific to the venom of each of these insects. They were also able to demonstrate several antigens common to the venom and to the body of each of these insects.<sup>5</sup> Langlois et al then attempted to demonstrate the location of the antigens shared by these several insects, as to whether the genus common antigens were localized in the venom or in the bodies of the insects. They demonstrated that in general those antigens common to all species of Hymenoptera were located in the bodies of these insects; however, they were able to demonstrate one antigen common to both wasp and yellow jacket, located in venom of these insects. They then concluded that it is possible for an individual stung by a wasp to be sensitized to yellow jacket by means of the common antigen existing in their venom. As for bee, it seems probable that an individual must become sensitized to the insect body antigens in order to have antibodies which cross-react with yellow jacket and wasp.<sup>6</sup> The manner in which a patient becomes sensitized to these insect body antigens is unknown, although inhalation of insect desquamations has been implied by some authors.<sup>25</sup>

## Reactions to Hymenoptera Insect Stings

### *Classification*

Reliable determinations of the components of venom are limited by technics in obtaining uncontaminated specimens. A new technic involving electrical stimulation for natural collection of venom devised by Benton is promising. A recent investigation by Schulman, et al<sup>24</sup> utilizing this technic, revealed that bee venom contains one prominent antigenic component, and this component is specific for venom. It could not be found in the body. Further studies utilizing this technic should be helpful in answering the questions pertaining to venom components.

### *Characteristics*

When foreign substance, such as venom, is injected parenterally in a human being, there is usually no severe reaction from the first sting; but with repeated stings, delayed hypersensitivity appears first; then local immediate reactions and finally generalized immediate reactions occur with increasing severity with each subsequent sting until the typical clinical image of acute anaphylactic shock is produced. Occasionally, individuals can develop a severe systemic reaction from a second sting.<sup>4</sup>

### *Etiology of Reactions*

Reactions to insect stings can be discussed under



two headings: 1) ordinary local reactions and 2) extraordinary local or general reactions. The usual local reaction consists of an intense burning local pain, followed minutes later by swelling and itching of the local area. The local reaction is limited to a few square centimeters, subsides after a few hours, and all symptoms usually disappear within 24 hours. Extraordinary local or general reactions, listed in order of decreasing frequency, include: 1) abnormal swelling and irritation, lasting longer than 24 hours; 2) massive urticaria and edema; 3) shock and collapse, loss of consciousness with hypotonia, tachycardia, followed by mild pyrexia and sometimes diarrhea and polyuria; 4) dyspnea soon after sting; 5) sudden severe systemic symptoms including hot flush over the body, severe dyspnea, wheezing and coughing, choking, generalized trembling, great anxiety, sometimes coma; and 6) death, usually within 15 minutes. The first three categories of extraordinary reactions have been estimated to occur in two per cent of all stings.<sup>14</sup>

### *Mechanism of Fatal Reactions*

It has been known for years that certain individuals respond to Hymenoptera stings with severe and even fatal reactions. Waterhouse in 1914 was first to notice the similarity of these reactions to anaphylactic shock in experimental animals and he suggested this as the mechanism of reaction in humans.<sup>1</sup>

Prior to that it was thought that toxic agents in the venom were responsible for fatal reactions, when, by chance, the venom was injected intravenously. As noted earlier, the venom of Hymenoptera insects indeed does contain rather potent pharmacological ingredients and has been compared in potency as being equal drop by drop to that of rattlesnake venom. Though the venom is toxic, there is not sufficient quantity of venom injected with one sting to account for severe reactions. Estimates of volume of venom injected with each sting has varied greatly, though the most realistic and repeated estimate is 0.05 cc. A case report in which a beekeeper reportedly received 75 stings in one day without untoward effects and another in which an 18-month-old child received 477 stings, after which he suffered shock and anuria but survived with adrenalin therapy are evidence against toxicity of venom causing severe reactions.<sup>13</sup> It is becoming more evident now that hypersensitivity is responsible for severe reactions as evidenced by the usual history of previous stings without reaction, suggesting sensitization; the time interval from sting to onset of symptoms; the resemblance of symptoms to classical anaphylaxis and the dramatic response to epinephrine and antihistamines. In recent years other evidence has been added by the demonstration of offending antigens in insects

and by the demonstration of specific antibodies in sensitive individuals.<sup>1</sup>

### *Influencing Factors*

For the past four years the Insect Allergy Committee of the American Academy of Allergy has been compiling a registry of persons allergic to insect bites or stings. By February, 1964, 2,606 cases were recorded and analyzed. These statistics reveal some interesting findings on the etiology of insect sting reactions.<sup>22</sup> The proportion of males registered exceeded that of females in every age bracket up to age 20. After age 20 the number of females registered increased. Fifteen per cent of males 12 years of age and under reported severe reactions, as compared to 14% of females in the same age bracket. Over the age of 12, 33% of males reported severe reactions as compared to 22% of females in a comparable age group. There was a sharp rise noted in the proportion of serious reactions after age 30 in both sexes, suggesting increasing sensitivity as the total number of stings received mounts over the years.<sup>22</sup>

### *Previous Exposures*

General reactions may occur without a previous unusual local or systemic reaction to a sting. Of 421 persons reporting slight general reactions, 18% could not even recall a previous sting. Of 1,135 moderate-general reactors, 17% could not recall having been stung ever before and 50% had been previously stung without any unusual reaction. Of 630 severe-general reactors, 38% had previously experienced one or more general reactions; whereas 61% gave no history of previous unusual reactions.<sup>22</sup>

### *Allergy History*

A personal history of hayfever, asthma, or other specific evidence of atopy was given by 27% of the registrants alluded to previously. An additional 28% of registrants gave a history of atopy in blood relatives.<sup>22</sup>

Other factors analyzed by the Insect Allergy Committee revealed August as the month with the highest incidence of insect sting reaction, and there was no tendency for stings to be lesser or greater in severity towards the end of Summer. Yellow jackets, bees, and wasps were named in that order as the most frequent offenders. More moderate and severe reactors named yellow jackets as offenders than did persons with local or slight general reactions.<sup>22</sup>

Fatal reactions to insect stings are commonly ruled secondary to anaphylaxis only on the basis of sudden death and frequently without autopsy. Recent investigation by McCormick<sup>10</sup> on detection of venom antibodies in victims' serum by gel diffusing technics



to determine the nature of the insect responsible for death may lead to improved diagnosis. As to the mechanism of death in fatal reactions, there is a vast lack of concrete evidence. O'Connor reviewed the death certificates of all cases listed by the United States Bureau of Vital Statistics under the heading of, "Death From Wasp Stings," between 1957 and 1959. Of 42 cases with sufficient evidence to determine the probable mechanism of death, only three showed death resulting from asphyxia due to laryngeal edema and five showed significant edema possibly contributing to death. Thirteen of the 42 cases reported death due to some type of heart failure. In 22 of the 42 cases, the cause of death was specified simply as anaphylactic shock.<sup>7</sup> An autopsy report by Schenken<sup>9</sup> performed on a 21-year-old white male with typical description of anaphylactic reaction following a bee sting showed the right atrium and right ventricle dilated twice normal size, superior vena cava and inferior vena cava greatly distended, a plug of thick, tenacious mucus in lower trachea associated with a large amount of frothy material, marked edema of epiglottal folds, and cerebral edema. The remaining organs were reported normal. His impression was death secondary to anaphylactic shock as result of severe hypersensitivity to bee sting. It seems likely that fatal reactions to insect stings do represent a form of anaphylaxis, but more autopsy studies are needed to confirm this supposition.

### Treatment of Reactions

#### *Immediate Treatment*

Treatment of insect sting reactions is determined by the severity and magnitude of the reaction. Antihistaminic ointment is beneficial for local reactions. The use of ammonia water by lay people is based on the erroneous idea that formic acid is the principle offending agent.<sup>14</sup>

#### *Intermediate Treatment*

Treatment for severe insect sting hypersensitivity should be considered from the standpoints of immediate, intermediate, and long term care. The immediate care for anaphylaxis demands the prompt administration of aqueous epinephrine 1:1000; 0.3 to 0.5 cc should be injected IM or deep subcutaneous or IV. There is no place in the early moments of treatment for such agents as antihistamines or corticosteroids.<sup>16</sup> If there is no response to epinephrine, calcium gluconate 10-20 cc of 10% may be given IV.<sup>14</sup> If shock persists, in spite of epinephrine, it may be necessary to give a sympathomimetic agent such as Aramine. Sublingual isoproterenol may be useful

in some cases, but this drug does not combat shock. If the stinging mechanism remains in the skin, it should be removed with a scraping motion of a finger nail or scalpel blade. Antihistamines may be given IM to combat the prolonged effects of the allergic emergency. Corticosteroids may be given in dosages 4-8 mg IM to prevent such delayed reactions as urticaria.<sup>16</sup> Tracheotomy and oxygen may be necessary in cases of angioedema of the larynx.

#### *Long Term Treatment*

Every person who has survived one or more generalized insect sting reactions should have long term hyposensitization. The American Academy of Allergy has studied 647 persons allergic to insect stings who have been hyposensitized and subsequently re-stung. Of these 647 persons, four per cent reported a worse reaction than was experienced previous to treatment; six per cent felt their subsequent sting reactions were unchanged and 90% described improvement over their pretreatment state.<sup>22</sup> Although there should be no question about the wisdom of such immunization, there is some disagreement about the type of therapeutic antigen and the method to use. Loveless<sup>27</sup> recommends the use of pure wasp venom given with an adjuvant. She estimated that the single repository injection gives protection for a period of four to six months. Deliberate stings several weeks after treatment indicated good immunity in her patients. Loveless cautions against using extracts of whole bodies of insects. She maintains that the insect sting injects only venom, hence the sensitization must be to venom and not to whole insect body protein. She fears that the injection of extraneous proteins may lead to development of periarteritis or a similar disorder.

### Hyposensitization

Hyposensitization with extracts of whole bodies of insects is the method most commonly used. Though there may be merit in the argument of Loveless against such therapy, there has been no evidence produced to substantiate her stand. Mueller<sup>12</sup> uses mixed whole insect extract of equal parts of bee, wasp, and yellow jacket. He uses dilution 1:100,000,000 for the initial skin test to determine the degree of hypersensitivity. He starts with 0.05 cc injection (dilution determined by skin testing) and increases with weekly increments until a dose of 0.2 or 0.3 cc of 1:100 is reached. He gives all patients a maintenance dose approximately every four weeks during insect season and every six weeks during the winter months. He empirically treats for three years, though he feels that it may be possible to maintain resistance with a booster dose four times yearly after the first year. Forty per cent of his treated patients have subse-



quently been re-stung and all have demonstrated a reduction in severity of reactions.<sup>12</sup> After evaluation of their data on allergic individuals treated with hyposensitization, the Insect Allergy Committee of the American Academy of Allergy recommended unanimously that hyposensitization be given to persons who have suffered even a mild systemic immediate-type reaction. This protective procedure is limited mainly by the fact that approximately 50% of systemic reactions are not preceded by a milder systemic reaction.<sup>22</sup>

### Summary

In summary, fatal reactions to Hymenoptera insect stings account for a considerable number of deaths each year. The best treatment available today for severe insect sting reactions is prophylactic treatment by hyposensitization. The benefit of prophylactic hyposensitization is limited to those persons forewarned with unusual reactions to previous stings. For those hypersensitive persons not forewarned, their fate is dependent upon the availability of immediate and appropriate medical treatment.

A better understanding of the components of venom and, consequently, of the hypersensitive reactions involved may be forthcoming with recent advances in technics of obtaining pure venom.

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## AMA DUES INCREASE VOTED AT 115th ANNUAL CONVENTION

At the 115th Annual Convention of the AMA held at Chicago, June 26-30, 1966, the House of Delegates approved, by a vote of 168 to 46, an increase in AMA annual dues from \$45 to \$70, effective January 1, 1967, thus confirming a Board of Trustees recommendation which was given initial approval at the 1965 Clinical Convention.

The House, in approving the dues increase, accepted a reference committee statement which said:

"It is quite apparent that the programs necessary to serve the needs of the members of the Association can-

not be conducted effectively without adequate financing and it is equally apparent that such adequate financing is impossible without the dues increase requested by the Board of Trustees. Your Reference Committee reaffirms its confidence in the judgment of the Board of Trustees which has in the past and must in the future exercise the most careful and prudent stewardship over the assets of the Association. The Board of Trustees is the Committee elected by the House of Delegates to investigate and control the finances of the Association. The appointment of any other committee to perform this function would be most inappropriate."



# THE VALUE OF DIAGNOSTIC PNEUMOMEDIASTINUM

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- Wide application of this simple and safe technique is advocated.

**D**IAGNOSTIC PNEUMOMEDIASTINUM is the intentional introduction of gas (either carbon dioxide or oxygen) into the mediastinal tissue planes to investigate abnormalities of the mediastinum and adjacent structures.

Using conventional techniques, the nature of a given mediastinal mass is often difficult or impossible to determine with assurance. Although helpful, fluoroscopy, plain and over-penetrated chest roentgenograms, laminagrams, and even angiography frequently fail to provide sufficient information for accurate diagnosis.

The technique of diagnostic pneumomediastinum, while not new, is not applied to these problem cases as frequently as its value warrants. It is the purpose of this case report to illustrate our modification of the technique of Hughes', et al,<sup>1</sup> and the important contribution made by this simple procedure to the management of the clinical problem.

## Technique

The patient lies supine on the radiographic table, and sterile technique is used throughout the procedure. Following infiltration of the skin and sub-

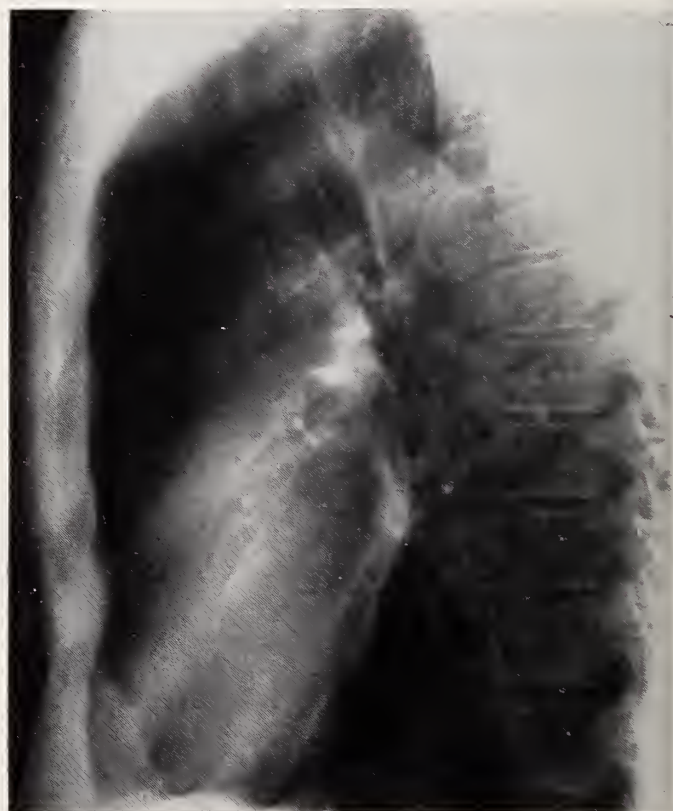
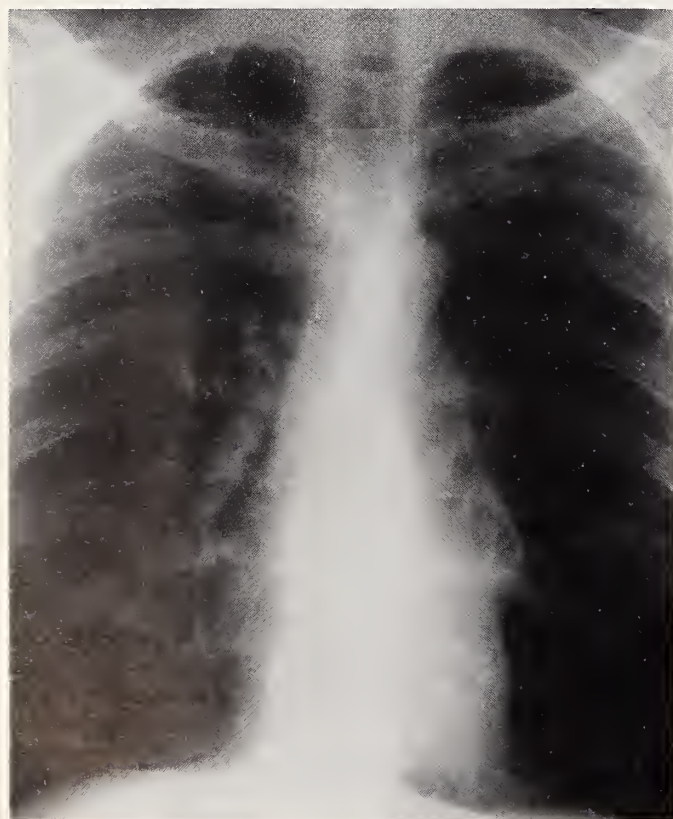


FIGURE 1 (A) AND 1 (B)

Posteroanterior and lateral chest roentgenograms demonstrating a prominent mediastinal mass in apposition to the left cardiac border. The mass is poorly defined on lateral view but is situated anteriorly, superimposed over the superior cardiac density.



cutaneous tissues of the subxiphoid area with local anesthetic, a 20-gauge spinal needle is inserted through the skin near the tip of the xiphoid so that the tip of the needle comes to lie immediately behind it. It is important to keep the needle nearly parallel with the skin, so that the needle tip will slide along the posterior aspect of the lower sternum. Following aspiration to make certain that a vessel has not been entered, a sterile polyethylene tube is used to connect the needle hub to a tank of oxygen, to which a reasonably accurate flow-meter is attached. Then, at an approximate rate of about 500-1000 cc. per minute, oxygen is allowed to flow through the system into the anterior mediastinal tissues. To prevent excessively rapid accumulation of oxygen in the tissues, an intermittent technique is used, wherein the gas is turned on for about 30 seconds, then off for about the same length of time. This procedure is repeated until the patient experiences definite substernal fullness or discomfort. At this time, percussion over the sternum produces a characteristic drum-like hyperresonance, confirming the fact that the oxygen is actually filling the anterior mediastinal space. Routine roentgenograms, as well as laminagrams, are obtained at this point.

Occasionally, several hours following the procedure patients will experience mild chest discomfort but simple analgesics are sufficient for this problem.

A 49-year-old white male was in generally good health except for symptoms of a mild respiratory infection, but chest roentgenograms (Figure 1) demonstrated a left mediastinal mass in the area of the left atrial appendage. Suggested diagnoses included pericardial defect with atrial appendage herniation, cardiac tumor, thymoma, and teratoma. The fluoroscopist thought intrinsic pulsations in the lesion could be identified. A pulmonary angiogram was unremarkable; no opacification of the mass was seen. A cardiac scintiscan, using a mixture of  $\text{Hg}^{197}$ -chlormerodrin,  $\text{I}^{131}$ -Cholografin, and  $\text{I}^{131}$ -RISA was interpreted as within normal limits. Lateral laminograms failed to show the mass separate from the heart. Pneumomediastinum was performed. With the benefit of oxygen in the tissue planes, a large, oval, pedunculated tumor situated anterolaterally was demonstrated, *quite separate from the heart* (Figure 2). This latter disclosure removed the necessity for having the heart-lung machine ready for use at thoractomy. A left anterior thoracotomy (Dr. William Logan) revealed a pedunculated tumor measuring 7 x 12 cm. connected to the main body of the thymus gland. Histologic examination revealed the tumor to be a benign thymoma. The patient recovered without incident.

### Summary

A more frequent use of diagnostic pneumomediastinum



FIGURE 2 (A) AND 2 (B)

Frontal and lateral laminagrams of the chest demonstrating the mediastinal mass to be extracardiac. The oxygen has dissected into the anterior mediastinal tissue planes and separated the lesion from the heart.



## PNEUMOMEDIASTINUM / Goodwin

tinum in the evaluation of mediastinal lesions is encouraged, and its value is emphasized by an illustrative case report. The simple and safe technique described makes possible a wide application of the

procedure, which can be easily performed in any radiology department.

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## SOUTHEASTERN INTERNISTS SCHEDULE SCIENTIFIC MEETING

The American College of Physicians (ACP) will hold a scientific meeting for internal medicine specialists in its Southeastern Region on October 7-8.

The meeting will be held at the Buena Vista Hotel-Motel in Biloxi, Mississippi, for doctors in Alabama, Florida, Georgia, Louisiana, Mississippi and South Carolina.

The regional meeting is one of 30 scientific sessions sponsored each year by the ACP throughout the United States and Canada and in the Far East. It serves to help keep College members abreast of developments in the

basic sciences and clinical medicine. The ACP represents some 13,000 specialists in internal medicine and related fields.

Irving S. Wright, M.D., New York, New York, ACP President and Professor of Clinical Medicine at Cornell University Medical College, will be a special guest.

The meeting is under the general direction of a committee of governors with Wesley W. Lake, Sr., M.D., of Pass Christian, Mississippi, ACP Governor for Mississippi and Associate in Medicine at Tulane University School of Medicine, as host Governor.

## 1966 CALENDAR OF MEETINGS

### State

September 18-20—Ninth Annual Medical Progress Assembly, Birmingham, Ala.

September 19-20—Eighteenth Annual Scientific Sessions of the Georgia Heart Association, Aquarama, Jekyll Island, Ga.

September 26-27—Tennessee Valley Medical Assembly, Trivoli Theater, Chattanooga, Tenn.

September 29-30—Seminar on Diabetes sponsored by the Florida Diabetes Association, Deauville Hotel, Miami Beach, Fla.

October 1—Fourth Medico-Legal Workshop, sponsored by the Crime Laboratory, Dept. of Public Safety; Medical Examiners, State of Georgia; Medical Assn. of Ga., and the Assn. of Pathologists, Center for Continuing Education, Athens. For information contact: Mr. George M. Murphy, University of Georgia, Institute of Government, Athens, or Herman D. Jones, M.D., Box 1456, Atlanta 30301.

October 20-22—Symposium on "Industrial Medicine: The Doctor's Role in Occupational Health," sponsored by the Mound Park Hospital Foundation, St. Petersburg, Fla.

October 27-29—Postgraduate course—Seminar on Neurology-Neurosurgery sponsored by the College of Medicine, University of Florida, Gainesville, Fla.

November 10-12—Pediatric Seminar, "Metabolic and Nutritional Disorders in Children," sponsored by the College of Medicine, University of Florida, Gainesville, Fla.

November 17-18—Obstetrics and Gynecology Seminar sponsored by the College of Medicine, University of Florida, Gainesville, Fla.

December 8-9—"Pediatrics," sponsored by the Medical College of Georgia, Dept. of Continuing Education, Augusta.

April 30-May 1-2, 1967—113th Annual Session of the Medical Association of Georgia, Marriott Motor Hotel, Atlanta.

### Regional

September 8-10—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.

September 16-17—Otolaryngology Seminar sponsored by the College of Medicine, University of Florida, J. Hillis Miller Health Center, Gainesville, Fla.

September 22-24—The American College of Cardiology Regional Meeting; and the Fifth Annual Cardiovascular Seminar, "Cardiovascular Emergencies," sponsored by the College of Medicine, University of Florida, J. Hillis Miller Health Center, Gainesville, Fla.

October 1-7—The Annual Otolaryngologic Assembly of 1966 sponsored by the Dept. of Otolaryngology of the College of Medicine of the University of Illinois, Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

October 7-8—The American College of Physicians, Southeastern Regional, Buena Vista Hotel-Motel, Biloxi, Miss.

### National

September 15, 1966-June 15, 1967—Nine month tutorial program in Cardiology offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

October 7-14—American Academy of General Practice, War Memorial, Boston, Mass.

November 27-30—American Medical Association (Clinical Convention), Las Vegas, Nev.



# HYPERPARATHYROIDISM

Asa G. Yancey, M.D.; Theresa D. Cachuela, M.D.;  
William N. Harper, M.D., and Delutha H. King, M.D., *Atlanta*

## ■ A clinical summary with case presentation.

**T**HE CLINICAL PICTURE produced by a hyperactive parathyroid adenoma has been recognized as such for only about 40 years.<sup>14</sup> These adenomas are uncommon, and accordingly, when suspected by a physician who sees one only rarely, can cause a great deal of concern as to whether the adenoma is or is not present. An involved surgeon does not wish to begin a fruitless, extended exploration of the neck. He wishes to be as reasonably certain as is humanly possible that exploration is warranted. Therefore, we wish to report the occurrence of a parathyroid adenoma which was diagnosed and removed in a modest-sized hospital and to list the various tests which may be used to indicate the presence or absence of a parathyroid adenoma. We hope that, thusly, doctors will be encouraged to search, chemically, for these adenomas more frequently and to carry out surgical exploration when indicated.

The Hughes Spalding Pavilion opened in 1952 and has had 58,906 admissions through 1965. During these years, there have been 18,636 surgical procedures performed. No parathyroid adenoma was found during these 14 years and no surgical exploration was carried out in search for a parathyroid adenoma, until this case, herein, described.

### Case Report

F.E.C., #43492 is a Negro female (aged 51 years) who was admitted on February 16, 1966, and discharged on March 11, 1966. Her admitting complaint was pain about an umbilical hernia and upper abdominal discomfort. The hernia was reduced with mild difficulty. X-rays of the abdomen revealed a staghorn calculus in the left kidney and a large right ureteral calculus (See Figure 1). No abnormal mass was palpable in the neck. Urinalysis—albumin—neg.; sugar—neg.; microscopic—few clumps of WBC. Repeat urinalysis showed over 100 RBC per high power field. Hematocrit 31; Hb. 10.6; WBC 15,950; V.D.R.L.—non-reactive. Blood pres-

sure 150/100; Pulse 100; B.U.N.—10.6; Fasting glucose—75 mgm.%. A roentgenogram of the chest revealed moderate cardiac enlargement. Cholecystograms were normal. Upper gastro-intestinal series was interpreted as a normal stomach and duodenum. Intra-venous and retrograde pyelograms established the presence of a left staghorn calculus and a right ureteral stone. Serum calcium studies were 13.0; 13.0; 13.0; and 13.85. Serum phosphorus studies were 2.25; 2.39; 2.85; and 2.20. Urinary calcium (Sulkowitch) showed calcium in excess. Alkaline phosphatase was 10.5 and 9.9. Exploration of the neck was performed on March 4, 1966, and a 7.55 gm. left inferior parathyroid adenoma was found



FIGURE 1

Roentgenogram which reveals a large right ureteral calculus and a staghorn calculus, left.



**HYPERPARATHYROIDISM / Yancey et al**

and removed. The parathyroid adenoma measured 3.3 x 2.7 x 1.2 cm. (See Figure 2). No other adenoma was found after a thorough search for an additional adenoma.

**Convalescence**

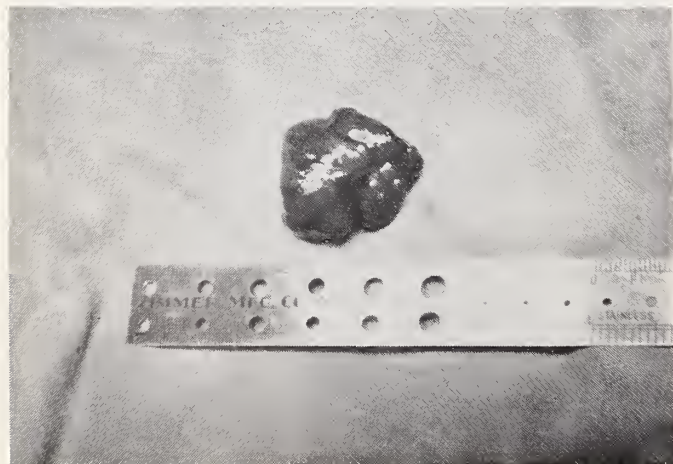
Post-operative convalescence was smooth except for bouts of nervousness relieved by oral and intravenous calcium gluconate. Tetany did not develop. Post-operative blood chemistry values were: Serum calcium—9.0; 8.3; 8.5; and 9.6. Serum phosphorus—3.60; 4.27; 2.70; and 3.43. Serum magnesium—1.9 and 1.66. B.U.N.—9.0; Serum sodium—150; Chloride—114; potassium—4.7; Creatinine—0.71. Tubular reabsorption of phosphates—98.4%.

The right ureteral stone was removed in May, 1966, and the umbilical and ventral herniae repaired, simultaneously. Convalescence was prompt and satisfactory after this operative procedure.

Hyperparathyroidism may be classified very similarly to hyperthyroidism, as:<sup>21</sup>

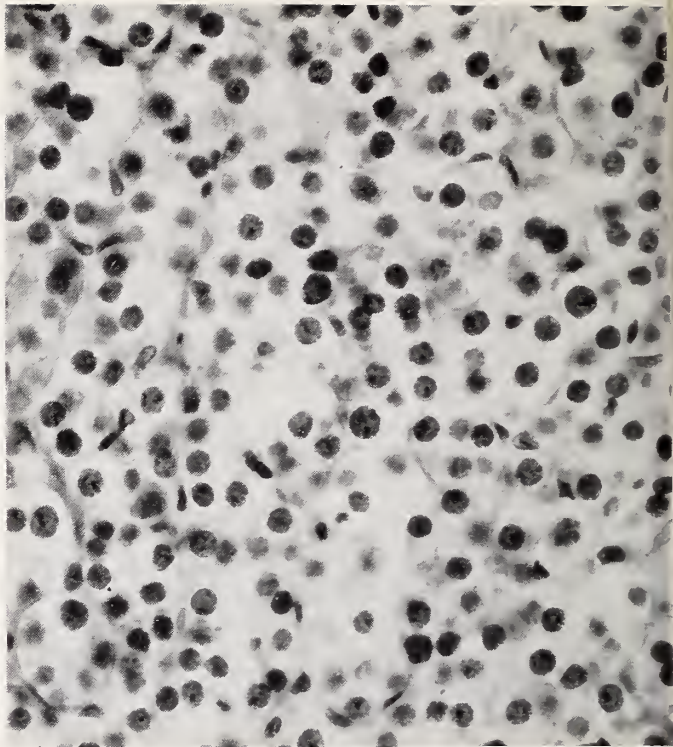
- (a) parathyroid adenoma
- (b) generalized parathyroid hyperplasia
- (c) functioning parathyroid carcinoma
- (d) parathyroid cyst

Parathyroid adenomas are more frequent in the female by a ratio of 3:2. The youngest patient with such an adenoma was 11 years of age and the oldest 76 years.<sup>23</sup> Seventy per cent of the parathyroid adenomas found had urinary stones or a history of having passed urinary stones as the leading clinical symptoms.<sup>6</sup> However, only about 5% or less of patients with urinary stones have parathyroid adenomas.<sup>20</sup> Virtually all urinary stones associated with hyperparathyroidism are radio-opaque. Bone disease led to the diagnosis of hyperparathyroidism in about 10% of the cases. Accordingly, approximately 20% of cases had neither urinary stones nor bone disease.<sup>6</sup> Other symptoms which suggest hyperparathyroidism



**FIGURE 2**

Inferior parathyroid adenoma, left, measuring 3.3 x 2.7 x 1.2 cm.



**FIGURE 3**

H. & E. stain. Photomicrograph of the parathyroid adenoma shown in Figure 2. Magnification X 310. The dominant cell was the chief cell.

and should stimulate one to search for this entity are muscular weakness; nervousness; persistent peptic ulcer; recurrent pancreatitis in the absence of alcoholism and gall-stones; mental aberrations; constipation; muscle and joint pains; polydipsia; polyuria; and the acute hyperparathyroidism crisis of fever, uremia, vomiting, cardiac arrhythmias, collapse and coma of unknown origin. Urgent removal of the parathyroid adenoma is most essential in a crisis of hyperparathyroidism.<sup>7</sup>

The table in Figure 4 summarizes the tests and procedures which may be of value in establishing a diagnosis of hyperparathroidism.

Other diseases which will cause an elevated serum calcium are sarcoidosis, metastatic carcinoma to bone, multiple myeloma, Cushing's syndrome, disuse osteoporosis, hypervitaminosis-D, skeletal xanthomatosis, certain bone cysts and tumors, and Paget's disease. The tests listed in the table of Figure 4 will aid in the differential diagnosis of these diseases.

Once the decision has been made that the patient has hyperparathyroidism, the calcium infusion test may suggest whether the defect is an adenoma or diffuse parathyroid hyperplasia. Anatomical<sup>11</sup> areas to search and points to be kept in mind while thoroughly searching for a parathyroid adenoma are:

1. Most adenomas involve the inferior parathyroids.<sup>13</sup>
2. Adenomas occur at equal frequency on right and left.
3. Less than 10% are in the thorax.



FIGURE 4  
DIAGNOSIS OF HYPERPARATHYROIDISM

Test or Procedure	Normal Value	In Hyperparathyroidism
1. Serum calcium .....	9.0-11.0	Increased (most valuable test) <sup>23</sup>
2. Serum phosphorus .....	3.4-4.5	Decreased (most valuable test) <sup>23</sup>
3. Renal clearance of phosphate .....	5-15 ml/minute	Increased
4. Urinary calcium (Sulkowitch) .....	150 mgm per day on low ca diet 225 mgm per day on regular diet	
5. Calcium infusion test <sup>18</sup> .....	Urine phosphorus decreased; Serum phosphorus increases. Rebound	Increased Autonomous adenoma urine phosphorus increased or remains constant. No rebound
6. Cortisone suppression of serum calcium	Depresses calcium in carcinoma, metastatic to bone	No change in serum calcium
7. Barium swallow X-ray .....	No filling defect	Defect seen. Rarely of value
8. Arteriography .....	Undetermined	Large adenoma may be visualized <sup>9</sup>
9. Tubular reabsorption of phosphate ...	78-90	Decreased
10. Selenium 75 methionine and photoscanning .....	Small uptake	Increased uptake

4. Superior and inferior thyroid poles and posterolateral surfaces of the thyroid lobes.
5. Within and along the carotid sheath.
6. Submanubrium space.
7. Within the thyroid gland.
8. Along the recurrent laryngeal nerve, but usually anterior to the recurrent laryngeal nerve.<sup>19</sup>
9. Along the tracheo-esophageal groove, retro-tracheal and adjacent to the esophagus.
10. Mediastinum.
11. Within the thymus.

### Complications

After removal of all detectable tissue which caused the hyperparathyroidism, it is to be noted that our patient did not develop carpo-pedal spasm. Most patients, by far, do not convulse nor show the severe tetany exhibited by carpo-pedal spasm. Mild tetany exhibited by paresthesia only is frequent. An occasional patient will develop a psychosis due to hypomagnesemia.<sup>12</sup> Intramuscular magnesium will promptly alleviate such an aberrant mental status.

### Conclusions

1. Parathyroid adenomas are rarely removed in small or medium-sized hospitals.
2. The diagnosis is a chemical one and the surgeon is frequently uneasy for fear of a fruitless and unnecessary, but extensive exploration.
3. Herein are listed the tests which are commonly available for establishing the diagnosis of hyperparathyroidism.
4. However, parathyroid adenomas do occur in small to medium-sized hospitals, and we should continue to suspect, test, and surgically search for such adenomas, as indicated.

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*The Hughes Spalding Pavilion  
35 Butler Street, S.E.*

## HIGHLIGHTS OF THE ACTIONS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING, JULY 24, 1966, ATLANTA

*This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.*

**MAG Legal Counsel Retainer Fee**, as increased by Council effective July 1, 1966, was agreed to by the MAG Attorneys with the provision that the matter be reviewed again next year.

**Bowdoin Commission Report on Milledgeville State Hospital** was discussed in detail by Commission member Dr. John B. O'Neal. It was recommended that certain items in the Report be presented to Council and that gubernatorial candidates be queried about their plans for Georgia's mental health program by MAG President Brown.

**Usual and Customary Fees** for Government programs was discussed and it was recommended that County Societies defer action on state programs until state departments can alter fiscal policies by budgetary authorization of the Georgia General Assembly in 1967 so as to allow for usual and customary reimbursement.

**Medical Review Committee** procedures for County and District Medical Societies were recommended so that the profession might advise with third parties in the handling of difficult claims.

**Title 6 (Civil Rights Law) Legal Implications** advised by MAG Legal Counsel to Fulton County Medical Society concerning regulations under the Social Security Medicare program was received for information at this time pending further developments.

**Federal Heart, Cancer & Stroke Program** was discussed and it was recommended that MAG Medical Education Committee and the MAG President coordinate activity with the two Georgia medical schools. A series of meetings has been scheduled for this purpose.

**State Board of Medical Examiners** liaison with MAG was approved and encouraged in response to a recommendation from a State Board member.

**Joint Commission on Accreditation** regulation on function of "hospital utilization committees" was re-

ferred to MAG Council per resolution from Georgia Medical Society. The resolution called for certain limitation to JCAH rules.

**Operation of Medical Laboratory** by lay personnel as infringement on the practice of medicine was discussed and authorization given MAG Legal Counsel to provide assistance to Fulton County Medical Society on this subject.

**MAG Field Service Representative** applications for such a position with MAG Headquarters Office Staff were discussed and arrangements made for interviews.

## PEDIATRIC SEMINAR TO BE PRESENTED BY UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

The Department of Pediatrics, College of Medicine, University of Florida announces a Postgraduate Seminar entitled *Recent Advances in the Diagnosis and Treatment of Metabolic and Nutritional Disorders in Children*. The seminar will be held from November 10 through November 12, 1966, at the University of Florida College of Medicine, J. Hillis Miller Health Center, Gainesville, Florida.

Guest Speakers will include the following:

Albert Dorfman, M.D., Professor & Chairman, Department of Pediatrics, University of Chicago School of Medicine

Gilbert B. Forbes, M.D., Professor of Pediatrics, University of Rochester School of Medicine

Norman Kretchmer, M.D., Professor & Chairman, Department of Pediatrics, Stanford University School of Medicine

Guy M. McKhann, M.D., Associate Professor, Department of Pediatrics and Medicine (Neurology), Stanford University School of Medicine

Charles R. Scriver, M.D., Associate Professor, Pediatrics, McGill University School of Medicine

Marvin D. Siperstein, M.D., Professor of Internal Medicine, Southwestern Medical School, The University of Texas

Faculty members of the Department of Pediatrics and other faculty members of the College of Medicine will be participating in the seminar.

Registration fee of \$50.00 should accompany application to attend. For further information write to Dr. Charles V. Lowe, Department of Pediatrics or the Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville, Florida.



# DIABETES AND PREGNANCY

## THE OBSTETRICAL ASPECTS

Richard L. Burt, M.D., *Winston-Salem, North Carolina*

- The effect of diabetes on pregnancy is generally related to the duration, severity, and degenerative changes that exist.

**C**LINICALLY, DIABETES MELLITUS is a disease of great antiquity, the first description being attributed to Celsus in the first century A.D. Until the introduction of insulin, however, diabetes was a rare complication of pregnancy. The essential incompatibility of untreated diabetes and pregnancy is indicated by the paucity of reported cases in the literature during the pre-insulin era<sup>1</sup> when maternal and fetal losses were high and amenorrhea, infertility and abortion excessive. At the present time diabetes is no longer a rare pregnancy complication, as it is generally reported to occur in 1 in 400 or 1 in 500 live births, but despite metabolic control, certain problems persist. For example, little is known concerning the etiology of pathologic pregnancies complicated by diabetes, the basis for the increased incidence of congenital malformations or the increased perinatal losses. The diagnosis of prediabetes during pregnancy likewise remains an unsolved problem, although an important one, because of fetal wastage in women destined to become diabetic. The medical and obstetrical management of the diabetic patient is dictated by the effect of pregnancy on the diabetes as well as the effect of diabetes on the pregnancy, and the selection of time for delivery of the patient is an important determinant of fetal survival.

### Diagnosis

The diagnosis of diabetes involves special considerations because of certain physiological changes in pregnancy. Noteworthy is the occurrence of glycosuria which was first described by Blot in 1856. The incidence of spontaneous glycosuria is variously reported from 5% to 10% to as high as 90% during the last six weeks of pregnancy.<sup>2</sup> It is quite obvious that reducing material in the urine does not have the same significance in pregnancy as in the non-preg-

nant patient. It appears that the glycosuria is related to the rather large increase in glomerular filtration rate, the excess glucose presented to the kidney tubule being lost. As lactose is a low threshold material, it is commonly found as term approaches as well as in the puerperium. Despite the physiologic basis for reducing material in pregnancy urine, if glycosuria is persistent or occurs in any significant amount it must be investigated.

### Significance of Tolerance Tests

The precise significance of abnormal oral glucose tolerance tests in pregnancy remains uncertain. With this test from 5%-10% to over 80% abnormal curves have been reported.<sup>3</sup> The variance encountered in this testing procedure is tremendous even in groups of patients who have been screened negative for obstetric history of fetal wastage or family history of diabetes.<sup>4,5</sup> Until the basis for the variance in the oral loading test is established, it seems improper to label patients with the diagnosis of prediabetes on the basis of lag curves repeatedly observed in apparently normal patients. As noted by a number of authors, the intravenous route is much less subject to variance and although the sensitivity of this procedure has been questioned it is not subject to false positive results in metabolically normal women.<sup>6</sup> The tolbutamide tolerance test is not a useful diagnostic adjunct in late pregnancy because diabetic-like blood sugar falls are quite consistently observed.<sup>7</sup> This is probably attributable to insulin resistance which is normal for pregnant subjects in the third trimester. It is of incidental interest that fasting blood sugar levels are normal or low normal in pregnancy.<sup>6</sup>

The effect of diabetes mellitus on pregnancy is generally related to the duration, severity, and degenerative changes that exist. In particular, the outcome of



pregnancy appears to be related to the degree of control. In most clinics acute toxemia is believed to be increased although this is not consistently seen.<sup>8</sup> Polyhydramnios is generally significantly increased, although the basis for this is not established. It does not appear to be related to fetal hyperglycemia, but it is associated quite definitely with an increase in incidence of congenital malformations. Fetal loss remains significantly large in most reported series and averages approximately 15%. Fortunately, maternal loss with good medical control is no longer a problem. Fetal malformation is increased, the incidence being generally reported at approximately 6%.<sup>8</sup> Spontaneous abortion with metabolic control is about the normal expectancy of 10%, but diabetic patients tend to have an increased incidence of premature labor.

The effects of pregnancy on diabetes and carbohydrate metabolism generally are quite well established. It appears that pregnancy is "diabetogenic," although the basis for this is speculative.<sup>6</sup> Clinically, the metabolic error of the diabetic patient increases with the progress of pregnancy as evidenced by decreased carbohydrate tolerance and an increase in insulin requirement generally after the 20th week. Immediately postpartum the insulin requirement reverts to the pre-pregnancy level. Transitory diabetes has been reported by various authors during pregnancy.<sup>9</sup> Metabolically, the transitory diabetic is indistinguishable from the patient with fixed permanent diabetes mellitus, but glycosuria and hyperglycemia disappear immediately following delivery. Certain data indicate that pregnancy is truly diabetogenic and the incidence of diabetes has been related to parity.<sup>10</sup>

### **Consistent With Clinical Behaviour**

Consistent with the clinical behaviour of the diabetic in pregnancy is the development of resistance to certain effects of exogenous insulin administration.<sup>6</sup> Blood sugar falls after intravenous insulin injections are decreased, as does the production of lactic acid and the fall in concentration of amino acid nitrogen in plasma. This increased tolerance to insulin does not appear to be due to insulin degradation, because the effects on the lipid components of peripheral blood plasma are not changed and are equivalent to those of non-pregnant subjects.<sup>11</sup> It seems unlikely, too, that the attenuation in insulin effects is accountable on the basis of increased binding by plasma proteins. In association with the noted insulin resistance is the occurrence of hyperlipidemia which is quite comparable to that of the diabetic patient.<sup>12</sup> Free cholesterol and cholesterol ester as

well as plasma triglycerides and non-esterified fatty acids are all increased. In addition, insulin-like activity of plasma is approximately twice non-pregnant control levels.<sup>13</sup> All of these changes resemble those seen in the acromegalic patient and may be related to the recently described placental lactogenic hormone.<sup>14</sup>

### **A Collaborative Effort**

In general, the management of the pregnant diabetic patient is a collaborative effort on the part of the internist and the obstetrician. At the outset of pregnancy the patient must be carefully evaluated with reference to her metabolic and cardiovascular renal status. The presence of diabetic nephropathy is very ominous for prognosis and may in certain cases justify therapeutic abortion. The patient must be carefully educated in the necessity of dietary control and vigilance in the routine determination of urine sugar and acetone. Close cooperation with the obstetrician is stressed together with the necessity for prenatal visits on a weekly basis. Any abnormalities noted by the patient, particularly any change in regulation, must be reported immediately.

Criteria for control are clinical as well as chemical. Weight must be maintained or normal weight allowed. Patients should be free of symptoms referable to diabetes or insulin excess. In particular, ketosis must be assiduously avoided. Glycosuria is minimized by appropriate dietary and insulin adjustment. A low sodium intake is desirable and an abundant fluid intake should be prescribed. Vitamin B complex supplementation is recommended because of the possibility of borderline thiamine deficiency. Chlorothiazide related compounds are prescribed when needed to control sodium and fluid retention. With any change in regulation beyond that expected because of the pregnancy itself, infection should be sought, particularly of the urinary tract.

Premature delivery in the 37th week has become widely recognized as an important measure to avoid late intrauterine death during the last three weeks of pregnancy. Delivery before the 37th week may be necessary in certain cases with obstetrical complications. If the patient is obstetrically favorable, amniotomy followed by oxytocin stimulation may be carried out. Should labor not ensue promptly, cesarean section should be performed.

During labor or at the time of surgery, long acting insulins are discontinued and the patient is maintained on sliding scale regular insulin. Hydration is maintained by parenteral glucose in water covered with regular insulin and should ketosis develop it is promptly corrected. Analgesia must be minimized as for premature delivery generally and anesthesia should be of the conduction type. Expert pediatric



care is required for the infant and premature nursery facilities must be available. Following delivery, the patient's insulin requirement generally is decreased by 50% and during the early puerperium she is carefully re-titrated with regard to the amount of insulin required. Prior to delivery and in the early puerperium, prophylactic penicillin is prescribed as an adjunctive measure to prevent surgical infection. Breast feeding is not advocated because of its metabolic implications.

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LAS VEGAS HOST TO AMA CLINICAL CONVENTION

A scientific program especially designed for the physician in practice is scheduled for the 20th Clinical Convention of the American Medical Association.

The four-day meeting here November 27-30 will include scientific sessions on 18 major topics, three postgraduate courses, breakfast roundtable conferences, closed-circuit television and medical motion picture programs, and a variety of scientific exhibits.

Of special interest are the postgraduate courses, which have been expanded to three topics: Obstetrics and Gynecology, Fluid and Electrolyte Balance, and Cardiovascular Disease. Each course will consist of three half-day sessions, each of which will feature several outstanding teachers. There will be a \$10 registration fee for each course.

Lively Discussion

Lively discussion should be a feature of four Breakfast Roundtable Conferences. The topics: "An Agonizing Reappraisal of Cancer Chemotherapy," "The Problem and Potential of LSD," "The Management of Metabolic Bone Disease," and "Indication for Cardioversion."

An outstanding program of closed-circuit color television and more than 25 medical motion pictures will be presented.

Topics at the scientific sessions include: scintillation scanning, radiation and cancer, clinical pulmonary physiology, gastroenterology, futuristic diagnostic and therapeutic tools, neck pain, antibiotics, urology, aerospace medicine, unconsciousness, dermatology, juvenile diabetes, endocrine and metabolic diseases, pediatrics, surgery, hematology, psychiatry, and otolaryngology.

Scientific and industrial exhibits and all scientific meetings will be in the newly expanded Las Vegas Convention Center.

The AMA House of Delegates will meet in the Dunes Hotel and Caesar's Palace.

The Eighth National Conference on the Medical Aspects of Sports will be held in conjunction with the Clinical Convention. A day-long program of discussion of problems faced by team physicians at all levels of athletic competition will be discussed. The meeting will be Sunday, November 27, at Caesar's Palace.



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Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side Effects:** Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.



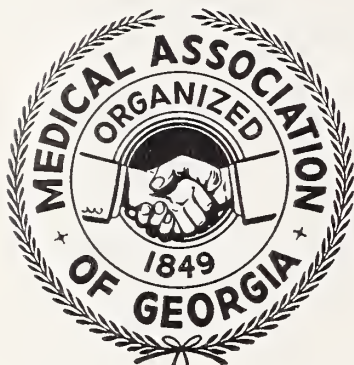
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# 1967 Annual Session

April 30-May 1-2, 1967 – Atlanta, Georgia



## First Call for Scientific Papers

All titles must be submitted to the  
respective program chairmen listed  
below before November 1, 1966

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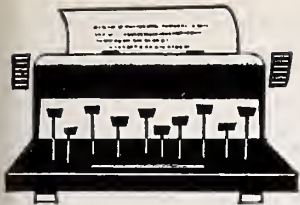
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## Insect Stings

**T**HE AUTHOR OF "Reaction to Hymenoptera Insect Stings" (See page 373) is to be greatly commended, inasmuch as this is one of the most complete and up-to-date computations of the data surrounding stinging insect venom hypersensitivity that I have seen in recent years. Every physician, regardless of his specialty, should become familiar with the principles of this paper, inasmuch as with the increased frequency of allergic reactions to the venom of the stinging insects, it is likely that every single physician will sometime during his life have some personal experience with a severe allergic reaction, and it is important that he be prepared to advise concerning the immediate and the long term prophylactic therapy. Relief from the mild or moderate local reactions may be obtained from the antihistamines orally in full therapeutic dosage for the usual one to three days necessary for this reaction to subside. Treatment of the marked local reaction, such as massive swelling of the entire extremity, resulting from a single sting, requires in addition to the antihistamine in full therapeutic dosage, the addition of steroids in full therapeutic dosage for the days necessary to resolve the inflammation of the extremity. This usually varies from two to seven days, but on occasion may require as long as 14 days. The steroids may be given to anyone without fear for seven to 14 days in a single course. The immediate local reaction usually occurs within 30 minutes; the delayed local reaction usually developing substantially by 12 hours, perhaps increasing in severity to a maximum at 24 to 48 hours. However, a commonly overlooked complication is the presence of secondary infection that may be introduced as a puncture wound into the tissue by the sting of the insect. These insects are scavengers and the stinger is usually contaminated with soil bacteria including possibly the tetanus bacillus. The presence of a secondary infection is usually indicated by the beginning of an acute inflammatory process about 24 hours after the sting and being manifested by erythema, heat, swelling and pain with perhaps redness along the lymphatic drainage channels with regional nodes in the appearance of tender regional lymphadenopathy and occasionally systemic indications of infection such as fever, etc.

Antibiotics, preferably the Tetracycline compounds, are indicated here. Obviously a tetanus toxoid booster is also indicated with an insect sting. Desensitization has not been recommended for the individual manifesting mild or moderate local reactions; however, for the individual manifesting a marked or massive local reaction such as massive edema of the extremity or area involved, while not mandatory, it is certainly worthwhile to most patients even though there is some cost in time and money. Another indication for desensitization of an individual with a local and no systemic reaction is the appearance of progressively increasingly severe and marked local reaction with repeated stings. This is interpreted as a prelude to the onset of the systemic reactions.

### For Immediate Systemic Reaction

Epinephrine is the drug par excellence for the therapy of the immediate systemic reaction. This should be given immediately and repeated every five to ten minutes indefinitely and as long as needed to resolve the immediate reaction. The patient or a member of his family may also safely be instructed in the immediate administration of this drug. The necessary equipment may readily be assembled into a kit by the average physician from his office supply or a packaged kit with labels and directions may be purchased from the allergy supply houses or in most cases any large pharmacy. Shock, accompanying the immediate reaction, is an indication for the administration of corticosteroids. These should be given in large pharmacological rather than physiological doses immediately, intravenously if possible, but intramuscularly otherwise and repeated in large dosage every four hours until a problem of shock has been resolved. Obvious supportive therapy, such as intravenous fluids and sympathomimetic agents are being used also. The corticosteroids may be continued for seven to 14 days if urticaria and angioedema or a generalized serum sickness-like reaction develops.

### Sublingual Isoproteranol

Sublingual Isoproteranol is useful and very adaptable in the individual whose manifestation of hypersensitivity consists of urticaria or angioedema of the



surface of the body or of the larynx or in the appearance of asthma or dyspnea. The present evidence seems to be that the hypersensitive symptoms will continue to be manifested in the same way as the initial reaction, only occurring sooner and becoming more marked as further stings occur. Therefore, you can expect subsequent clinical reactions to reproduce the one first experienced by your patient and you can prescribe the appropriate medication for the type of reaction to be expected. The sublingual Isuprel or even Isuprel by inhalation is satisfactory for the individual with urticaria, angioedema or asthma. This may be carried at all times by the susceptible individual and used promptly and repeated every five to ten minutes if needed. Apparently the individual who manifests urticaria does not suddenly change and begin to manifest anaphylaxis conversely.

### A Specific Therapy

Insect hypersensitivity is a disease for which there is a specific and completely adaptable therapy. Desensitization, if properly planned and carried out, will protect 100% of individuals. The failures, according to literature, even including the statistics of the American Academy of Allergy, are due to failure to properly plan and faithfully carry out the necessary immunization. Commercial extracts prepared from the whole body of the insect are satisfactory and may be obtained from any allergy supply house. The patient is skin tested to each of the four stinging insects (the bee, wasp, yellow jacket and hornet), using about two or three hundredths of a one to one million dilution of venom and immediate reactions are read in 20 minutes. Inasmuch as two out of every ten sensitive individuals will be allergic to the venom of more than one insect, it is then necessary to prepare an extract containing all of the venoms or antigens to which the individual has shown a positive reaction.

This may then be administered by the technique advised and supplied by the allergy supply laboratory. If the clinical reaction was one of anaphylaxis and if the individual knows or thinks he knows the identity of the insect which stung him or produced the severe reaction, then a second and concomitant desensitizing injection should be administered, using the venom of the suspected or known insect alone. It is not permissible to stop when one reaches a dosage of two-tenths or three-tenths cc of the one to one hundred extract and assume that this is adequate for maintenance therapy and administered every month. This volume should be increased by five hundredths cc with each monthly injection to as large a volume as the individual can stand, up to one cc, using the local reaction at the site of the desensitization injection or even the appearance of systemic symptoms as a guide. The theory of optimal dosage of antigen does not apply in this example of clinical allergy. A monthly booster dosage of the largest volume tolerated should be administered for 36 monthly dosages, and then it is felt that one should have enough stored up immunity to last a lifetime; further booster dosages are not necessary. This same type of immunization may be obtained by using the emulsion repository methods. This problem should be referred to the allergist who is trained in the administration in this form of therapy and may consist of either one single or up to four emulsion repository injections per year for some three years, depending on his experience and results of his own particular emulsion; this of course has the added advantage of reducing markedly the number of injections necessary and the time and trouble in most cases. The expense is less also.

It cannot be overemphasized that this is a specific disease for which a specific therapy is available to each and every person needful of it.

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## Call for Annual Session Papers

WITH OUR LAST Annual Session having been held four months ago, it may seem a bit premature to begin thinking about the Annual Session scheduled for Spring of 1967. Actually, for those of us designated as Section Chairmen for the upcoming meeting, the year 1967 seems to be approaching at a much accelerated pace.

Our deadline for submission of scientific papers

has been set at *November 1, 1966*. We, as Section Chairmen, are all anxious to receive as many good papers as possible in order to round out a first rate scientific program. We are all aware that a medical meeting can be no better than the quality of its scientific presentations. Because of this, we feel on the spot to produce such a program for the Annual Session in Atlanta in May of 1967.

In order to firm up plans for the meeting, all the Section Chairmen met at the Headquarters Office in Atlanta on August 7. Section Chairmen present were:

*Anesthesiology*—Thomas L. Tidmore, M.D.; *Chest*—Walter S. Dunbar, M.D.; *Diabetes*—Edwin C. Evans, M.D.; *Dermatology*—Robert M. Fine, M.D.; *General Practice*—Robert E. Huie, M.D., and Thomas Q. Spitzer, M.D.; *Medicine*—W. C. Waters, III, M.D.; *Obstetrics and Gynecology*—John R. McCain, M.D.; *Ophthalmology and Otolaryngology*—W. S. Hagler, M.D., and J. Gordon Brackett, M.D.; *Orthopedics*—F. James Funk, M.D.; *Pathology*—Lester Forbes, M.D.; *Pediatrics*—J. Rhodes Haverty, M.D.; *Psychiatry*—Sheldon B. Cohen, M.D.; *Radiology*—Richard A. Elmer,

M.D.; *Surgery*—Charles E. Todd, M.D.; *Public Health*—T. O. Vinson, M.D., and *Neurosurgery*—H. D. Richardson, M.D.

At this session definite plans were formulated for an outstanding annual meeting in 1967. These ambitious plans cannot and will not materialize unless our loyal members throughout the state come forth and submit their really worthwhile papers for presentation.

Please help us to make your next Annual Session an outstanding scientific meeting.

*Edwin C. Evans, M.D.*  
*Section Chairman,*  
*Georgia Diabetes Association*

## **MAG AND FARM BUREAU CO-SPONSOR RURAL HEALTH CONFERENCE**

The Medical Association of Georgia and the Georgia Farm Bureau are co-sponsoring the Second Annual Georgia Rural Health Conference, October 13-14, 1966, at Rock Eagle State 4-H Club Center near Eatonton, Georgia. Farm and rural area leaders from over the state will meet to discuss rural health needs, problems and programs.

Mr. William L. Lanier, President of the Georgia Farm Bureau, will deliver the Conference welcome and Dr. Ben Saltzman, Chairman of the AMA Council on Rural Health, will present a talk on, "Your Individual Responsibility for Health Maintenance." The Communicable Disease Center, U. S. Public Health Service, is slated for a presentation on, "Immunization—A Method of Insuring Your Health," and "Poultry Products and the Threat of Salmonella."

### **Program Variety**

The Agricultural Extension Service, University of Georgia, is scheduled to discuss "Farm and Home Safety," and the award winning 4-H Health Demonstration Project will be presented. The Rev. John Crow, Clinical Chaplain Supervisor of the Georgian Clinic, will speak on the subject, "Religion and Medicine in the Treatment of the Alcoholic." Another topic at the Conference will be, "The New Medicare Program and How To Use It," given by Mr. Douglass Richard, Regional Director, Bureau of Health Insurance, Social Security Administration.

Joint planning of this Conference by the Farm Bureau and the MAG Committee on Rural Health is designed to promote the continuing health education of farm leaders from throughout the state of Georgia.

## **SCIENTIFIC SECTION MEETINGS SET FOR 1967 MAG ANNUAL SESSION**

The Medical Association of Georgia scientific section meeting program chairmen have set final plans for continuing medical education programs to be convened at the Association's 1967 Annual Session slated for April 30-May 2, at the Marriott Motor Hotel, Atlanta. The program chairmen, representing all the major specialty societies in Georgia, scheduled the scientific section meetings for both Sunday afternoon, April 30 and Monday afternoon, May 1.

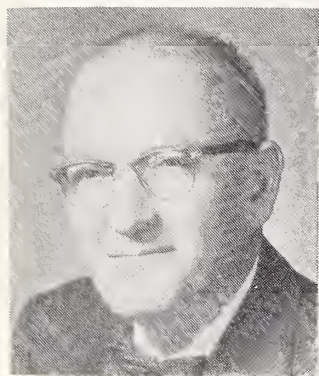
### **Section Meetings**

An individual breakdown of the section meetings is as follows: Sunday afternoon, April 30 from 2:00 p.m. to 5:00 p.m.—(1) General Practice, Obstetrics & Gynecology, Psychiatry and Public Health; (2) Pediatrics and Radiology; (3) Pathology; (4) Orthopedics; (5) Dermatology; and (6) Neurosurgery.

On Monday afternoon, May 1 from 2:30 p.m. to 5:00 p.m. sections will meet as follows: (1) Obstetrics & Gynecology; (2) General Practice, Medicine and Diabetes; (3) Chest and Surgery; and (4) Orthopedics.

Most of the specialty societies are planning luncheons, dinners and business meetings in conjunction with the section meetings at the MAG Annual Session. As at the 1966 Columbus Annual Meeting, the MAG House of Delegates will convene Monday morning, May 1, and again for their final session on Tuesday morning, May 2. MAG General Business meetings are slated for the same mornings in combined meetings with the House. Traditional activities such as Medical School Alumni dinners will be held Sunday evening, April 30 and the MAG President's Banquet is scheduled for Monday evening, May 1.





## PRESIDENT'S LETTER

### Poverty Programs

*"A man's fortunes are the fruit of his character." . . .*  
*Emerson*

SEVERAL YEARS AGO a *Saturday Evening Post* cover showed two row houses in a slum area. One was run down, with doors hanging, windows broken, and yard littered with cans and debris. On its porch the fat, bewhiskered, unkempt owner snored lazily. The house next door, however, was neat and well kept. The windows shone; the grass was green and clipped. A white fence surrounded the small yard, and the owner, dressed in clean work clothes, was busily planting flowers down the walk-way.

#### Unused Potential

The painting spoke with force! Poverty is a lack of material goods, but slums are commonly due to inadequate or unused potential in a human being.

That some human beings are inadequate by reason of poor heredity cannot be denied. Inferior protoplasm begets more. Sterilization laws are sorely needed—a touchy question, but a necessary one. As our population grows, it is evident that our nation needs to breed its best, rather than its worst. Such laws would help to decrease much disease, crime, and other problems which confront our society. In this area, the medical and legal professions should work with politicians to legislate laws which are just to all.

#### A Desire to Advance

Secondly, all aid to the poverty-stricken must be based on the individual's desire to advance. Vocational Rehabilitation is such a program. Much good has been done, with little money wasted. Those who have the motivation to work today can make a good living. In cases of poorly motivated people, "give

away" programs based on "need," a basic Communist tenet, only perpetuate and magnify the problem. Building brick houses may simply create new slums, and free food often destroys the slum dweller's one motivation, that of need. Franklin Roosevelt in 1935 cautioned, "Continued dependence upon relief induces a spiritual and moral disintegration fundamentally destructive to the national fibre. To dole out relief in this way is to administer a narcotic, a subtle destroyer of the human spirit."

Third, religion must be revived as a force in the life of our nation. Ideals must be generated to serve as guidelines. Whatever beliefs are accepted must be lived as a seven day a week creed, not a Sunday a week expurgation. Our problem is not a poverty of material goods, but instead a poverty of moral strengths. From poverty stricken, yet religious homes of the past have risen many of the great men of our country. Poor people, yes, but also industrious, law abiding, and God-fearing.

#### Our Aim

To breed our best and to offer everyone the chance to achieve maximum potential should be our aim. The medical man who sees the progeny of disease, mental insufficiency, and immorality every day in his practice must actively advise in the field of legislation. If he speaks and works persuasively, perhaps he will be heeded. For poverty is not the disease but merely a sign of the disease. Treating symptoms and signs of illness are of no therapeutic value unless the underlying disease itself is also attacked.

*Lamar B. Peacock, M.D.*  
*First Vice President*  
*Medical Association of Georgia*



## THE DOCTOR AND CANCER DETECTION

Charles P. Adams, M.D., *Atlanta*

“**G**EORGIANs ARE developing cancer at the rate of one every hour—24 new cases each day—9,500 new cases each year. One person dies of cancer here in Georgia every two hours—4,945 deaths each year.”

### The Magnitude

When viewed statistically, the magnitude of the cancer problem is overwhelming. It is the second most common cause of death. It is the leading cause of death in women.

It is estimated that one-third of all cancer patients are cured or survive five years at the present time. It is also estimated that one-half of all patients with cancer could be cured if knowledge now available were applied to them.

Cancer can begin in any organ of the body. About 70% of the patients who died last year in Georgia had cancers arising in ten body organs. Unfortunately, almost 50% of the patients who died in Georgia last year from cancer had their disease originate in one of five body organs that lend themselves to early detection or prevention. These are breast, uterine-cervix, colon-rectal, mouth and lung.

With the increased dissemination of information to the lay public by all media, the importance of breast examination, a pelvic examination with a “Pap Smear,” digital and sigmoidoscopic examination of the rectum, examination of the oral cavity, and chest x-rays, are being realized and asked for by the patients. The significance of these examinations has been stressed in previous articles on this page.

Since July 1, 1966, the number of medically indigent patients in Georgia has sharply decreased and since an increasing number of insurance companies pay for their policy-holders to have routine examinations, we as physicians have an increased responsibility to examine those patients with one of the “Seven Danger Signals,” and specifically to examine the above five areas in those 65 and over. Last year 46% of the patients who died from cancer in Georgia were in the 65 and over age group. These examinations do not require a “specialist” but can be performed by every practicing physician.

*478 Peachtree St., N.E.*

Approved by the Professional Education Committee, Georgia Division, ACS.

## MAG HOLDS SIXTH ANNUAL CONFERENCE ON SPORTS INJURIES

The sixth annual Conference on Sports Injuries, sponsored by the Committee on School Child Health of the Medical Association of Georgia was held in Atlanta on August 4, 1966, at the Academy of Medicine.

Scheduled to coincide with the annual high school coaches clinic and high school all-star football game, this year's conference drew a representative crowd of physicians and athletic coaches from across the state. The conference is traditionally open to physicians, coaches, athletic trainers and educators.

Two out-of-state physician speakers, one high school football coach, and a panel of sports injury experts comprised the half day program. Dr. William R. Buttram,

Jr., Chattanooga, delivered a paper on, “Heat Problems in Sports.” Dr. Buttram is an internist and a recognized authority on this subject. Dr. Bruce Brewer, Milwaukee, Wisconsin, orthopaedic surgeon spoke on, “Musculo-tendinous Injuries in Athletes,” and coach Billy Henderson, Willingham High School, Macon, spoke on, “Conditioning for Athletics.”

A panel of these three participants plus Mr. Warren Morris and Mr. Buck Andel, Head Athletic Trainers at the University of Georgia and Georgia Tech, respectively, fielded questions from the audience in the anchor spot on the program. Dr. Fred Allman, Chairman of the Committee on School Child Health, served as conference chairman and moderator of the panel.



# what time is it?

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four thousand  
of U.S. population.

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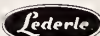
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### ANGINA PECTORIS—THE HISTORY

Dan Burge, M.D., *Atlanta*

**A** CORRECT DIAGNOSIS of angina pectoris may lead to the institution of a life-prolonging regimen of treatment. An incorrect diagnosis may condemn a patient to unwarranted fear of sudden death, to unnecessary restriction of activity, and to needless loss of earning power. *Physicians* have a responsibility to carefully take and shrewdly interpret the history upon which the diagnosis depends.

#### What Is It?

Angina pectoris is recurrent chest pain, induced by exertion or excitement, which is relieved by a short rest. The discomfort may be felt anywhere in the chest—anteriorly or posteriorly, right or left. Typically, the pain is retrosternal, often at the level of the second, third or fourth rib. It is often felt over the precordium. If the pain is sharply localized to the cardiac apex area, angina pectoris is not likely to be the correct diagnosis. Infrequently pain may be confined to the epigastrium or either costal margin. The distress is often confined to the chest but may radiate to neck, jaw, shoulder or to either upper extremity. Occasionally angina is felt in one of these latter areas *without* chest pain.

The pain is usually dull, *rarely* sharp or stabbing. It is often described as *squeezing*, *constricting*, or *pressing*—occasionally as *expanding*. Sometimes the patient will *deny* pain since the feeling of tightness doesn't fit his definition of pain, or he may interpret the feeling in his chest as shortness of breath. Careful questioning will enable the clinician to avoid both of these pitfalls. Fear of impending death, or, rarely, syncope may accompany the anginal episode.

True angina rarely lasts longer than three minutes after the pain compels the patient to rest. Pain similar to that of angina may last from five to 30 or 40 minutes in so-called "coronary insufficiency." This

type of pain comes on at rest, often following exertion. Nitroglycerine taken sublingually during a bout of angina will give relief within 60 to 90 seconds. It is important to ask the patient how long it takes this drug to give relief. If he replies that it does so in five or ten minutes, then it is obvious that nitroglycerine has had no influence.

#### When It May Occur

Angina pectoris may occur at complete rest, but if it is not also induced by exertion in that patient, the diagnosis should not be made. Characteristically, walking rapidly, particularly uphill, will induce an episode. It is rare for angina to result from use of the arms in a patient who doesn't experience it on walking or climbing. Pains may come with less exertion, after heavy meals or in cold weather, than is required at other times.

The frequency of episodes varies from once every several months on unusual exercise to dozens of times a day on trivial exertion. Occasionally tenderness and hyperesthesia overlie the site of the pain during bouts.

The ECG and exercise tests *may* support the diagnosis. Physical examination and laboratory studies *may* give evidence of predisposing conditions such as thyroid dysfunction or diabetes. However, the diagnosis of angina pectoris is made or excluded by proper evaluation of what the patient *tells* about his complaint.

At times uncertainty persists because of inconsistencies in the history, or because of atypical features. In these patients coronary arteriography must be employed to resolve the doubt.

*21 Eighth Street, N.E.*

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



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AMES



### RECENT GEORGIA STATUTES

John L. Moore, Jr., *Atlanta*

**I**T IS FREQUENTLY surprising to see how many bills introduced into the General Assembly of Georgia affect the health of Georgia citizens and therefore are interesting to physicians. It seems that a run-down of a few of the statutes adopted in 1966 will be of interest to Georgia physicians.

#### PKU

Act No. 306, Ga. L. 1966, p. 140, directed the Department of Health of the State of Georgia to promulgate appropriate rules and regulations governing tests for phenylketonuria so that as nearly as possible all new born infants shall receive a test for phenylketonuria as soon after birth as successful treatment for such condition may be initiated. Parents may object to the test if it conflicts with religious tenets. The Department of Health was also authorized to adopt rules and regulations relative to other in-born errors of metabolism and any other conditions which may be indicated as a result of medical research.

#### Graduate Nurses

Applicants for registration as graduate nurses may now qualify by graduation from an associate degree program in nursing administered by junior colleges, colleges, or universities utilizing hospital and other clinical facilities, such program not to be less than two academic years in length. This amendment of Code Section 84-1008 reduces the previous three year requirement limited to accredited programs connected with a hospital of good standing.

#### Interning Requirement for Physicians

Act No. 429, Ga. L. 1966, p. 232, changes the licensing requirements for medical doctors licensed to practice medicine and surgery in Georgia. Graduation from an accredited medical school will entitle the applicant to take the examination of the State Medical Board and to receive an "interning license" giving him authority to practice medicine in the hospitals in Georgia but not otherwise. After giving satis-

factory proof to the Board that the applicant has had one year of training as an intern in a hospital in good standing with the Board, the applicant will receive a full license to practice medicine and surgery in Georgia. Of course, if he makes satisfactory proof of the one year's interning prior to taking the examination, he may receive a full license upon passing the examination administered by the State Board of Medical Examiners.

#### Family Planning

Act No. 427, Ga. L. 1966, p. 228, authorizes the State Health Department, county boards of health, health districts, the State Department of Family and Children Services and county and district departments of Family and Children Services to offer family planning services including counseling on birth control, infertility, and family planning, distribution of literature on those subjects, referral to licensed physicians or local health departments for consultation, examination, tests, medical treatment and prescription and, to the extent of available funds, the distribution of rhythm charts, drugs, medical preparations, contraceptive devices and similar products used for birth control and family planning. The rights of citizens not to accept such counseling or devices is guaranteed and the Act is very careful to state that no person's religious belief shall be offended by imposing birth control methods upon him as, for example, a condition to receiving public assistance or public health services.

#### Voluntary Sterilization

Act No. 534, Ga. L. 1966, p. 453, clarified the performance of voluntary sterilization procedures on married persons requesting them after consultation and agreement between two physicians. This Act was described in more detail in the April, 1966, issue of this Legal Page.

#### Funeral Service Contracts

Act No. 511, Ga. L. 1966, p. 398, sets up a statute regulating the sale of pre-need funeral service



## LEGAL PAGE / Continued

contracts. The Act vests the administrative power over persons selling such contracts in the Comptroller General of Georgia. No person may take money for a pre-need funeral service contract without being registered with the Comptroller General under the Act. The Act is designed to require persons selling such contracts to have sufficient net worth to perform all obligations under contracts. In addition, all funds received by the persons writing pre-need funeral service contracts from such contracts are to be deposited at interest within five days in a state bank, savings bank, trust company, national bank, or a federal savings and loan association located in and doing business in Georgia.

Any person who has previously purchased a pre-need funeral service contract may demand and receive from the bank holding the funds a refund of the entire amount actually paid on the contract together with all interest, dividends, increase and accretions received on the funds previously paid into

the depository. Apparently the seller of the contracts is not entitled to any offsetting charges. Of course, the supplier of the contract is entitled to withdraw the funds to satisfy the terms of the pre-need funeral service contract after death of the contracting party. The Act also contains provisions requiring proof by affidavit to the depository of the death of a contracting party before the funeral director can withdraw the funds deposited under the contract for the purpose of the funeral of the contracting party.

The Act appears to have sufficient teeth in it to protect persons purchasing such contracts and ought to be sufficient to prevent loss of deposited funds by persons who have dealt with financially unstable vendors of contracts.

*Suite 1220  
C & S Bank Building*

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*Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.*

## WYETH EXTENDS FELLOWSHIP PROGRAM FOR TENTH YEAR

Applications are now being received for Wyeth Pediatric Residency Fellowships that will begin on July 1, 1967. Sponsored by the Wyeth Fund for Postgraduate Medical Education, each of these fellowships provides \$4,800 over two years toward the advanced study required for Board Certification. Wyeth's monthly payments, made directly to recipients, are in addition to the usual stipends paid to residents by the institutions in which they train.

### Who Is Eligible?

Eligible to apply are interns, physicians who have recently completed an internship, research Fellows, or physicians leaving the armed services or U.S. Public Health Service.

The Wyeth Pediatric Fellows may serve their residencies at an institution of their own choice provided it is accredited by the AMA's Residency Review Committee of the American Medical Association, the American Board of Pediatrics, and the American Association of Pediatrics.

### Distinguished Pediatricians

A voluntary committee of distinguished pediatricians has the responsibility for choosing the Wyeth Pediatric Fellows. Wyeth plays no part in the selections.

Requests for application forms and inquiries about the program should be directed to the Committee Chairman, *Philip S. Barba, M.D., 120 Erdenheim Road, Philadelphia, Pa. 19118.*

## DRUG MANUFACTURER OFFERS FILM AND SELF-RATING SCALE ON MEASUREMENT OF DEPRESSION

"The Measurement of Depression" is a film depicting the development, validation, and use of a scale for the quantitative measurement of depression.

The scale was designed by Dr. William W. K. Zung, Durham, N. C., psychiatrist. Although initially devised for use in psychiatric research, it readily lends itself to the general practice of medicine where most depressions are first encountered.

The film is designed for medical educational purposes at meetings of hospital staffs, county societies or specialty groups. The self-rating scales, available in quantity for use in office practice, come complete with full instructions.

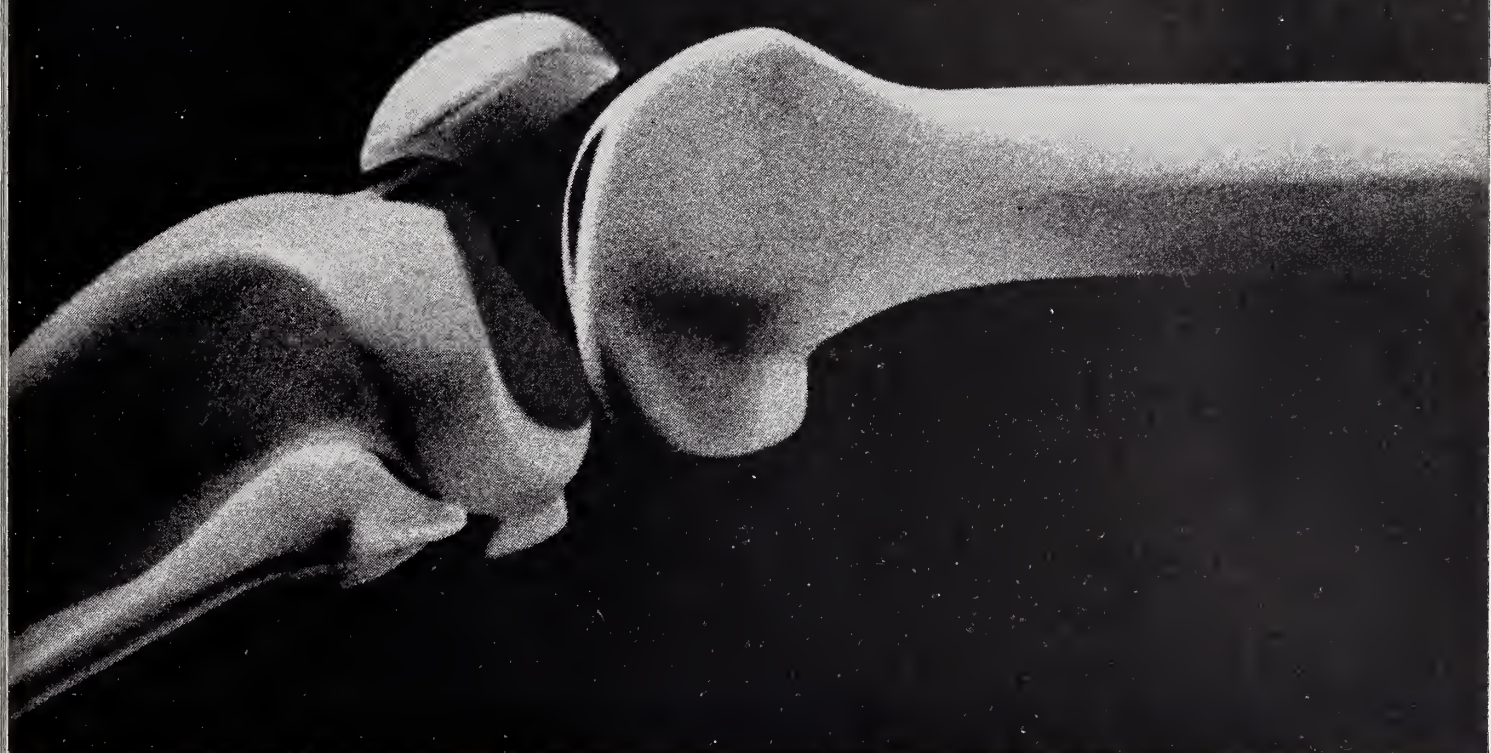
Both the film and pads of the self-rating scale are available free upon request from Lakeside Laboratories, Inc., Milwaukee, Wisconsin 53201.

The scale consists of a list of 20 statements expressed in the common language of the patient. The statements comprehensively delineate widely recognized symptoms of depression including disturbances of mood, biological and psychological function. Testing and scoring patients usually requires less than five minutes.

Statistical studies indicate that measurements so obtained correlate reliably with other more time-consuming depression rating scales in current use.

Use of the scale in a variety of patients with physical complaints without apparent organic basis may uncover and measure depression in so-called "hidden depressions" saving valuable time in the clinic and several sessions of probing interviews.





## Butazolidin® alka Usually works within 3 to 4 days in osteoarthritis

phenylbutazone, 100 mg.  
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The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month*.

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

### Contraindications

Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

### Warning

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

### Precautions

Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

### Adverse Reactions

The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be

attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

### Dosage

The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information.  
6509-V(B)

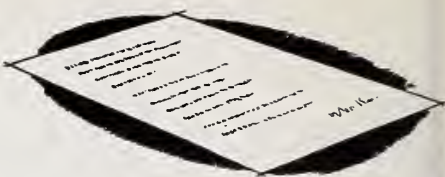
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Sprawls, Perry, Jr., M.S.; Miller, W. B., Jr., B.S.; Weens, H. S., M.D., and Casper, J. H., B.A., Dept. of Radiology, Emory Univ. School of Medicine, Atlanta, Ga., "Patient X-Ray Exposure During Fluoroscopic Examination with an Analysis of Contributing Parameters," *Radiology* 87:99-101(July)1966.

During fluoroscopic examinations the x-ray exposure to the patient is influenced by a number of parameters which are associated with the type of examination, the x-ray equipment used. The relationship of this x-ray exposure to several of these parameters has been the examining doctor, and the patient. studied and the results are reported here.

Variations in individual patient exposure can be attributed to variations in the following physical parameters:

- 1. Exposure area
- 2. Exposure time
- 3. X-ray machine output
- 4. X-ray beam quality
- 5. A complex function relating exposure of a specific point or organ, to the exposure of a specific surface area of the patient.

These physical parameters are influenced by characteristics of the x-ray machine, patient, and examining doctor. The x-ray exposure to a patient can either be expressed as radiation delivered to a specific point or organ (in Roentgens) or as the surface exposure integral (SEI, Roentgen-cm<sup>2</sup>).

The patient exposures and certain parameters resulting from barium enema and gastrointestinal examinations are shown in the following table.

	Average Exposure Area (cm <sup>2</sup> )	Average Exposure Time (sec)	Average SEI (R-cm <sup>2</sup> )	Male Gonadal Exposure (mR)	Female Gonadal Exposure (mR)
Barium Enema					
Staff	97	160	1550	333	546
Residents	105	205	2219		
GI Series					
Staff	58	272	1542	68	183
Residents	64	293	1980		

The percent of variation in the surface exposure integral which can be attributed to variations in the physical parameters of area, time, and machine output is shown in the following table.

	Area	Time	Machine Output
GI Series	56%	44%	2%
Barium Enema	34%	62%	11%

The patient-to-patient variation in gonadal dose is influenced by variations in gonad-to-exposed area distance and anatomical composition in addition to variations in exposure area, time and x-ray machine output.

Naib, Zuher M., M.D.; Nahmias, Andre J., M.D., and Josey, Wm. E., M.D., Emory Univ. School of Medicine, Atlanta, Ga., "Cytology and Histopathology of Cervical Herpes Simplex Infection," *Cancer* 19: 1026-1031 (July)1966.

Sixty-two of 40,000 patients screened by vaginal smears for cancer in the last three years at Grady Memorial Hospital-Emory University showed cellular changes compatible with herpes simplex infection. Thirty-two of these patients had biopsies and viral cultures attempted.

The cervical biopsies revealed four in situ carcinomas situated in the endocervical canal; six squamous atypia, ranging from mild dysplasia to marked dysplasia just short of in situ carcinoma. Eleven had acute cervicitis with vascular granular tissue formation; five had lesions histologically compatible with herpes simplex and six patients had no particular microscopic findings.

Twelve of the 32 viral isolation attempts were successful. A brief description of the cytological and histological findings is given. The high incidence (15%) of histologically proven squamous atypia, dysplasia and in situ carcinoma in cases where the cytology smears show herpetic cellular changes besides the ordinary pre-malignant and malignant cells is of particular interest.

The possibility of a relation between cervical atypia and a herpetic genital infection should be considered and further experimental work is being done at this time.

Brown, Wm. J., M.D., Communicable Disease Center, Atlanta, Ga., "Public Health Aspects of Syphilis," *Southern Medical Journal* 59: 639-642(June)1966.

Dr. William J. Brown, Chief Venereal Disease Branch writes in the June 1966 issue of the Southern Medical Journal that 1965 shows the highest rate of syphilis morbidity in a decade and one half. However, he states that the true figures may be five times as great.

Being so contagious, syphilis threatens not only the individual's health, but the community's as well. The end result is years of physical suffering and an expenditure of millions of dollars for the care of the blind, insane, and in man hours lost.

The burden of the program to eradicate syphilis lies with the private physician as he cares for 80% of all our cases. "We know how to get rid of it . . . we don't do it." We simply have not employed the advantages of diagnosis and treatment that science and technology have given us to our greatest potential.

We will eradicate syphilis by 1972 then, if we identify infectious cases initially, treat accurately, and report cases promptly so that both the source of a patient's infection and any persons infected by him are ministered at once. It is often important to treat on epidemiologic evidence alone, curing before the lesions appear to prevent additional spread cases. To provide the physician with this information and to assist him and the community, the PHS has a complex machinery of skilled epidemiologists interviewing, investigating, and testing for possible diseased contacts. Yet, they can only help when called upon.

Syphilis, then, because it affects communities, is a public health problem, requiring public health methods to eradicate it. All of us working together can and will eradicate this dread disease.

Manganiello, Louis O. J., M.D., Daniel, Ernest F., M.D., and Hair, Lawton Q., M.D., Medical College of Georgia, Augusta, Ga., "Lipoma of the Corpus Callosum: Case Report," *Journal of Neurosurgery* 24:892-894 (May)1966.

Lipomas of the corpus callosum are rare. Only 69 cases have been reported in the literature. This case was a 42-year-old white female with the main complaint of headaches.

X-rays of her skull showed typical ovoid midline calcification. Arteriogram and ventriculogram confirmed a tumor mass. Brain scan, first reported in literature of a lipoma of corpus callosum, showed no uptake of radioactive material. A craniotomy with biopsy of the tumor was done which confirmed the diagnosis of lipoma.

Because the patient was developing symptoms of intracranial hypertension,



a Torkildsen procedure was done. The patient's hospital course was uneventful. Her headaches disappeared.

The only psychiatric manifestation was that of euphoria.

**Letton, A. H., M.D., and Wilson, John P., M.D., Dept. of Surgery, Georgia Baptist Hospital, Atlanta, Ga., "Routine Cholangiography During Biliary Tract Operations; Technic and Utility in 200 Consecutive Cases," *Annals of Surgery* 163:937-942 (June)1966.**

The authors discontinued using routine operative cholangiography fourteen years ago because of technical difficulties. However, in recent years it was felt that this should be reinvestigated because when it is routinely reliably carried out one can find unsuspected common duct stones, it can prevent common duct exploration that would otherwise be necessary by the classical clinical indications, identify the number and location of stones prior to exploration, demonstrate unusual anatomy, etc. The disadvantages which have been proposed are primarily due to unreliability of films and the adverse effect of additional operative time. A technique was worked out on a cadaver using full strength hypaque, first injecting and then aspirating the dye which left a halo effect demonstrating quite small stones in each incidence. To evaluate its usefulness 200 consecutive cholecystectomies were reviewed. On 174 of these that had cholangiograms using the method described, 89.6% had classical indications to explore the duct. By cholangiography 78% of these were found to have normal ducts. Seventeen of these have been opened despite normal x-rays and no stones were found in any instance. Stones were found in 14 of the remaining 15 patients who demonstrated abnormal x-ray. This is one false-positive. Of the 105 patients who had no clinical indication to explore the duct there were nine abnormal x-rays and stones were found in six which is 5.7%. Of the group, eleven patients were found to have stones in the common duct of the 28 who had an acute gallbladder. This is 39.2%. The amount of time required to do the procedure averaged five minutes and 22 seconds. Film badges for radiation exposure were worn and revealed no significant radiation exposure by the operative team.

The secret of routine operative cholangiography is to have the team train to do cholangiography on all patients so that they are thoroughly familiar and reliable films can be made consistently.

**Humphries, Arthur L., Jr., M.D.; Shepherd, Mason H., M.D., and Peters, Hans J., M.D., Depts. of Surgery and Pathology, Medical College of Georgia, Augusta, Ga., "Peutz-Jeghers Syndrome with Colonic Adenocarcinoma and Ovarian Tumor," *JAMA* 197 (July 25)1966.**

PEUTZ-JEGHERS syndrome consists of intestinal polyps and intraoral melanin spots and is said to be hereditary.

The following case is presented because of the unusual combination of the Peutz-Jeghers syndrome and an ovarian neoplasm. Ovarian tumors are found frequently enough—in approximately 5% of females with the syndrome—to suggest that they are related to the same mutant gene. A papillary cystadenoma of the ovary was removed in this patient 26 years ago.

An invasive polypoid adenocarcinoma of the colon was removed eight years ago. How many of the polyps occurring in this syndrome are truly malignant is difficult to assess. Probably not very many is the opinion of Bartholomew and associates, not nearly as many as reported, since many of those reported were judged malignant because of mitoses, invasion of the stalk of the polyp, and cellular hyperchromatism. A fact that strongly supports their opinion is that apparently only two persons have been reported to have died from metastatic carcinoma that arose (presumably) from a Peutz-Jeghers polyp; a third person reported as having a non-resectable rectal carcinoma because of its extensive invasion of the sacrum is presumably dead now.

She is now asymptomatic.

**Ellison, Robert G., M.D.; McPherson, James C., Jr., M.D.; Yeh, Thomas J., M.D.; Anabtawi, Isam N., M.D., and Ellison, Lois T., M.D., Div. of Thoracic Surgery, Medical College of Georgia, Augusta, Ga., "Metabolic Consideration of Acid-Citrate-Dextrose Stored Blood for Extracorporeal Circulation," *The Annals of Thoracic Surgery* 2:540-550 (July)1966.**

The acid-base status was studied in 150 patients in whom blood stored in acid-citrate-dextrose solution was used

for open heart surgery. Blood gases were determined on the primed oxygenator and on patient's blood at various intervals during and after the use of the heart-lung machine. All patients were perfused at maximum flow rates equivalent to normal cardiac output.

The usual pattern was severe metabolic acidosis immediately after beginning bypass which progressively decreased during the perfusion. Frequently mild metabolic acidosis still existed immediately after bypass but in most instances the standard bicarbonate was normal by the end of the operation. With inadequate flow rates, short perfusions, metabolic alkalosis or in small children in whom the priming volume: blood volume of patient ratio was high, metabolic acidosis frequently was not spontaneously corrected.

This study indicated that blood stored for several days in ACD solution is usually acceptable for extracorporeal circulation.

**Galambos, John T., M.D., Dept. of Medicine, Emory Univ. School of Medicine, Atlanta, Ga., "Acid Mucopolysaccharides and Cirrhosis of the Liver," *Gastroenterology* 51: 65-74(July)1966.**

The relationship between human liver disease and hepatic acid mucopolysaccharides was studied in 666 cases in which adequate amounts of liver tissue were obtained for biopsy. The accumulation of histochemically demonstrable acid mucopolysaccharides in human liver lesions emphasizes the responsiveness of the hepatic mesenchyma in the pathogenesis of human liver disease. Chronic active liver disease was associated with the accumulation of acid mucopolysaccharides in a) the perisinusoidal space along parenchymal cells, b) in areas of necrosis, c) at the septal-parenchymal junction in cirrhotic livers. A vicious cycle of mesenchymal response—parenchymal injury could explain the progressive nature and persistence of chronic active liver disease in some patients. When acid mucopolysaccharides accumulate in areas of injury without infiltration into the lobular parenchyma, and before the development of collagen bundles, the mesenchymal reaction may still be reversible. Those types of hepatic lesions which were not associated with the accumulation of acid mucopolysaccharides were not regularly followed by fibrosis and cirrhosis.

## DEKALB MEDICAL AUXILIARY RECEIVES FOUNDATION AWARD

The Woman's Auxiliary to the DeKalb County, Georgia, Medical Society received a special achievement award for its outstanding efforts in the American Medical Association Education and Research Foundation program for 1965-1966.

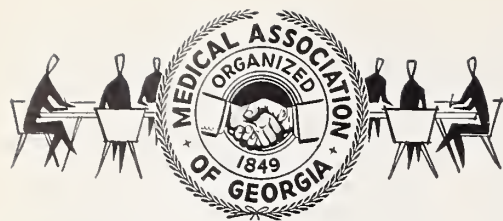
The presentation was made during the 43rd Annual Convention of the Woman's Auxiliary to the American Medical Association, held in Chicago June 26-30.

With a membership of 100, the DeKalb Auxiliary raised \$1,971.65 for AMA-ERF. Total national contribution was \$345,573.81, part of which will be given

to medical schools for unrestricted use. The remainder will go to the student loan guarantee fund. This fund makes possible long-term bank loans to medical students, interns and residents, with no payment due on either interest or principal until five months after completion of all training. AMA-ERF acts as guarantor. For each \$100 contributed, \$1,250 in loans is made available.

The 1965-66 DeKalb Auxiliary President was Mrs. George Statham. AMA-ERF Chairman was Mrs. Guilermo Nadal. Both are from Decatur.





# THE ASSOCIATION

## DEATHS

**David A. Bagley, Sr.**, of Austell, died June 19, 1966.

Dr. Bagley, age 85, had made his home in Austell for the past 30 years. He had practiced medicine in Austell with offices in his home until failing health forced him to give up his practice. He had been a patient in a private hospital for a year after a severe stroke last spring.

Survivors include one son, David Bagley, Jr., of Powder Springs, two daughters, Mrs. H. M. Land, Opelocka, Florida, and Mrs. R. P. Cooper of Dallas; six grandchildren and two great-grandchildren.

**Frank L. O'Connor**, 60, of Chattanooga, died August 3, 1966.

He was a licensed physician and surgeon in Tennessee and Georgia. He was a graduate of the University of Tennessee. He began his practice in Rossville, Georgia, in 1941 after serving his residency at the Henry Grady Memorial Hospital in Atlanta.

One of the founders of Tri-County Hospital, Dr. O'Connor was chief of staff at the hospital in 1958.

He was a member of the American College of Surgeons; Southeastern Surgical Congress; Southern Medical Association; Walker and Dade counties Medical Societies; Chattanooga and Hamilton County Medical Society; the American Medical Association and the Tennessee Medical Association. A member of the Veterans Association of the 6th U. S. Cavalry, Dr. O'Connor was a charter member and past president of the Rossville Kiwanis Club.

He was on the staff at Erlanger, Memorial and Tri-County hospitals and a member of the First Christian Church and the Fairyland Club.

He is survived by his wife, Mrs. Ellen Thomas O'Connor, Chattanooga; one son, Frank L. O'Connor, Jr., Chattanooga; one daughter, Mrs. Thomas F. Carrier, San Diego, California; one sister, Mrs. Vance Griffin, Memphis; and one granddaughter.

**Jesse Clayton Dover**, of Clayton, died June 23, 1966.

He had practiced medicine in Rabun County for 66 years, after his graduation from college in 1899. In addition, he served continuously on the Rabun County Board of Education since 1910 until his retirement in 1962.

He held an honorary life membership in the Georgia School Board Association and was honored during "Dr. Dover Day" in 1955 for his work in Rabun County.

Survivors include his wife, Mrs. Mary Simmons Dover; two daughters, Mrs. Claude Carter, Gainesville, Georgia, and Mrs. Byron Turner, Bradenton, Florida, and a son, Dr. Tom A. Dover, Athens, Georgia.

**James A. Johnson, Jr.**, member of the psychiatry department of the Emory University Clinic, Atlanta, died July 11, 1966.

He had left general practice in 1956 and had received psychiatric training at Milledgeville State Hospital, Boston State Hospital and Emory.

A past vice president of the Southeastern Group Psychotherapy Society, Dr. Johnson had published a number of articles on group therapy.

Surviving are the widow; sons, James A. Johnson, III, George C. Johnson, Carlton H. Johnson and Stephen A. Johnson, all of Avondale Estates; father, James A. Johnson, Sr., Manchester, Georgia; brothers, Dr. Edward Johnson, Chattanooga, and Dr. Lawson Johnson, Miami, Florida.

## SPECIALTY SOCIETIES

Dr. Julius Johnson, assistant clinical professor in the Department of Psychiatry at the Medical College of Georgia in Augusta, has been installed as the new president of the **Georgia Psychiatric Association**.

Other officers are Dr. August Yochem, Atlanta, vice president; Dr. Kenneth McDonald, Augusta, secretary; and Dr. Charles Fulghum, Atlanta, treasurer.

## PERSONALS

### Fourth District

**Welden Kelley** of Griffin has been named the Spalding County Society of the American Cancer Society's Volunteer of the Year. Dr. Kelley has been active in the cancer program in Griffin for several years and has held several offices.

### Fifth District

Dean of Emory University School of Medicine, **Arthur P. Richardson**, Atlanta, spoke to the Atlanta Civitans August 2, 1966, on the "Changing Face of Medicine."

**Robert P. Cunningham** of Atlanta has been appointed the new Assistant Medical Director of Southern Bell Telephone Co. and will assist **Joseph C. Read**, the firm's Medical Director. Dr. Cunningham has been in private practice in Atlanta since 1957. He is a graduate of Emory.

**John H. Venable**, Atlanta, Director of the Georgia Department of Public Health, has been named by President Johnson as the public health member of the National Health Resources Advisory Committee.

Visitors to the Crippled Children's Clinic, adjoining Aidmore Hospital in Atlanta, can now see hanging there a spanking new oil portrait of a man who has devoted his entire life to children.

A portrait of **William L. Funkhouser**, Medical Director of Aidmore since 1938 and a Georgia pediatrician for over 60 years, was unveiled on May 22 at a reception at the clinic honoring Dr. Funkhouser. The painting is the first to hang in a "Hall of Fame" planned to honor individuals who have made a significant contribution to the Health Department's Crippled Children's Service. Dr. Funkhouser has been Medical Consultant to the State Agency since 1941.

**Lester M. Petrie**, Director of the State Health Department's Preventable Disease Branch, was presented a National T.B. Association bronze medallion Service Award by the Atlanta Tuberculosis Association at their annual meeting on May 5, 1966.

The award was presented on behalf of the Board of Directors of the Association by **C. C. Aven**, long-time member of the Board and past president of the Association. Dr. Petrie has been an active member of the volunteer professional staff of the Atlanta Tuberculosis Association since 1934.

#### Sixth District

**Ernest Corn** and **W. A. Newman**, Macon, were presented momentos from the medical staff of the Middle Georgia Hospital. The two are planning to retire from over 50 years each of active practice. Presenting the citations were **Charles Richardson, Sr.**, **Jasper Hogan**, and **Herbert M. Olnick**.

#### Seventh District

**John Atha**, a native of the Rome area, opened offices with **T. E. Cummings**, Rockmart, July 1, 1966. Dr. Atha is a graduate of the Medical College of Georgia.

#### Eighth District

**Diskin G. Morgan**, Douglas, discontinued his practice of medicine the latter part of August and this month will begin a residency in surgery at Eugene Talmadge Memorial Hospital in Augusta.

#### Ninth District

**B. J. Roberts**, former Cornelia physician, has been named District Director of District 22 for the State Health Department, and will return to Cornelia to make his home. Dr. and Mrs. Roberts have been making their home in Jonesboro.

#### Tenth District

A psychiatry and neurology office has been opened at 1445 Harper St., Augusta, by **Kenneth Jones** who will be associated with **Julius T. Johnson** and **J. Kenneth McDonald**.

**G. A. Cyrowski**, who has been a resident in surgery in the Mayo Graduate School of Medicine, University of Minnesota at Rochester, has left that city and will be located in Augusta.

**Alfred Jay Bollet** has been appointed Chairman of the Department of Medicine at the Medical College of Georgia.

Dr. Bollet is a former professor of Internal Medicine and Preventive Medicine and Director of the Rheumatic Disease Research and Training Program and Chronic Disease Unit at the University of Virginia School of Medicine.

Announcement of the appointment was made by Dr. Harry B. O'Rear, college president.

**Glen E. Garrison**, former Medical Director of the Department of Continuing Education at the Medical College of Georgia, has been appointed Professor and Chairman of the newly created Department of Community Medicine at the college.

**Hans Peters**, Associate Professor of Pathology at the Medical College of Georgia, Augusta, has been awarded a three-year \$67,977 clinical cancer teaching grant by the Department of Health, Education and Welfare. The grant offers financial support for a tumor registry, programmed instruction, and a continuing education program of cancer teaching.

**Corbett H. Thigpen**, Chief of the Department of Psychiatry at the University Hospital, Augusta, spoke at the Wilkes County Courthouse in July. Dr. Thigpen spoke on constitutional government.

## QUERIES ON NEW MEDICARE LAW ARE ANSWERED

*Excerpts from questions posed by physicians in attendance at the MAG County Medical Society Leadership Conference, February 5, 1966, as answered by representatives of the Social Security Administration on the new "Medicare" law, P.L. 89-97.*

(1) *Deductible under the supplementary medical benefits plan (Part B) of Medicare.*

The law provides that the total amount of expenses incurred under Part B by an individual during a calendar year shall be reduced by a deductible of \$50.00. (The law permits the amount of the deductible for such calendar year to be reduced by the amount of any expenses incurred in the last three months of the preceding year and applied to the individual's deductible for that year.)

The \$50.00 deductible under Part B for a calendar year does not have to be paid; it must only be incurred. Also, this deductible applies to total expenses incurred during the year, and not to each physician's fee.

Payments for physicians' services covered by Part B will be made on a reasonable charge basis. The \$50.00 deductible will be subject to the same test of reasonableness as other expenses.

After the \$50.00 annual deductible has been met, payment can be made for 80% of the reasonable charges for the physician's (or other) services. Payment will be made by a carrier (1) to the patient on the basis of a receipted bill or (2) to the physician for an unpaid bill if the patient assigns payment to his physician and the physician agrees to the assignment and accepts the reasonable charge determination as the total amount of his bill.

Reimbursement by carriers for physician's and medical expenses under Part B will generally be made using the principle of applying the deductible and paying claims on the basis of incurred expenses as they are presented and proved to the carrier. This is in line with the practice already developed and currently followed in paying claims in the health insurance field.



# 1966-67

## MAG COMMITTEES

### I. STANDING COMMITTEES

#### EXECUTIVE COMMITTEE OF COUNCIL

President—Walter E. Brown, Savannah (1967)  
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Second Vice President—M. C. Adair, Washington (1967)  
Chairman of Council—Charles R. Andrews, Jr., Canton (1967)  
Secretary—J. Rhodes Haverty, Atlanta (1969)  
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Speaker of the House—J. Frank Walker, Atlanta (1968)  
Chairman of Finance—F. G. Eldridge, Valdosta (1967)

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Braswell E. Collins, Macon  
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2nd District—W. Frank McKemie, Albany (1967)  
3rd District—Luther H. Wolff, Columbus (1967)  
4th District—Luther M. Vinton, Jr., Decatur (1968)  
5th District—Robert Carter Davis, Atlanta (1968)  
6th District—T. A. Sappington, Thomaston, Chairman (1968)  
7th District—Lee Battle, Rome (1969)  
8th District—E. R. Jennings, Brunswick (1969)  
9th District—Rafe Banks, Jr., Gainesville (1969)  
10th District—M. C. Adair, Washington (1969)

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 William S. Hagler, Atlanta; Alt.: Gerald E. Wadsworth, Atlanta  
 Gordon Brackett, Atlanta; Alt.:  
 Robert Perry, Brunswick; Alt.: Hugh V. Bell, East Point  
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 Harry D. Pinson, Augusta; Alt.: John T. Mauldin, Atlanta  
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 A. Grigg Churchwell, Sandy Springs; Alt.:  
 Harvey Hamff, Atlanta; Alt.: James H. Smith, Rome  
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6th District—Milford B. Hatcher, Macon  
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10th District—Stewart D. Brown, Royston

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Robert E. Perry, Jr., Brunswick

## HOW TO HANDLE ADVERSE REACTIONS

I believe that, rather than summarily removing a useful drug from the market, it is better to rely upon the trained and intelligent judgment of the practicing physician. In the event that a drug has undesirable properties which are not commonly known, dissemination of information concerning those properties through channels such as the *Journal* or other medical publications is a far more sensible method of handling the problem.—George C. Manning, M.D., in *Journal of the American Medical Association* (197:61), July 4, 1966.

## THIS I BELIEVE ABOUT THE DRUG INDUSTRY

The drug industry has made significant contributions to our ability to care for the sick, done basic and worthwhile research in our behalf, and with our help as physicians, is a private enterprise for which we should be grateful. . . . For the things I dislike about some of their products, the men who represent them, and for some of their overly enthusiastic claims, I shall continue to make my complaints to the drug companies themselves, not to my fellow physicians. For the many more things that they have done to augment my practice in a wholesome and worthwhile way, I shall continue to support them. In the overall picture, the ethical drug companies are our allies in the private and public practice of medicine.—P. A. Overstreet, M.D., in *The Internist* (7:8), June-July, 1966.

## THE TEAM THAT DOES SO MUCH

Pharmacognosy, pharmacodynamics, pharmacology, pharmaceuticals, pharmacy—put them all together and they spell *medicine*—medicine for your patient and mine. But one doctor alone cannot put them all together without help. The fact that for so many centuries, doctors have appreciated this need for assistance in preparing medicaments, has created one of the most enduring patient care team relationships on record. . . . We cannot practice medicine without the pharmaceutical supply house. . . . As physicians, we cannot manage much of a future without *medicamenta vera*.—Editorial in *Pennsylvania Medicine* (69:78), April, 1966.

## EVERY PHYSICIAN A CLINICAL INVESTIGATOR

The individual physician holds a very important place in drug evaluation. A drug is studied on a relatively few patients before it is made generally available. The occasional patient who develops a serious side reaction could easily be missed. Very often it is only after the drug is used on thousands of patients that the occasional adverse drug reaction is noted, frequently by a general practitioner. Thus, the general practitioner, by properly reporting such a reaction, is a clinical investigator.—Arthur C. DeGraff, M.D., in *GP* (33:77), May, 1966.

## WHO MAKES THE DRUGS YOU USE?

I need hardly remind physicians that trade names usually are much more easily identified and remembered than generic but have the disadvantage that the same drug appears under a variety of trade names. Usually the physician sticks to the name he remembers and the company he trusts. Are trademarked drugs more reliable? In general yes, because the maker is identifiable. Generic name use tends to encourage the fly-by-night manufacturer who all too often sells drugs for legitimate use through the front door and to the rackets through the back. I would rather pay more for a tradenamed amphetamine than a cheaper amphetamine tablet which may largely participate in the goofball market. And then there are drugs, such as digitalis, that I would not dare use without knowing who made them.—Irvine H. Page, M.D., in *Modern Medicine* (34:104), June 6, 1966.

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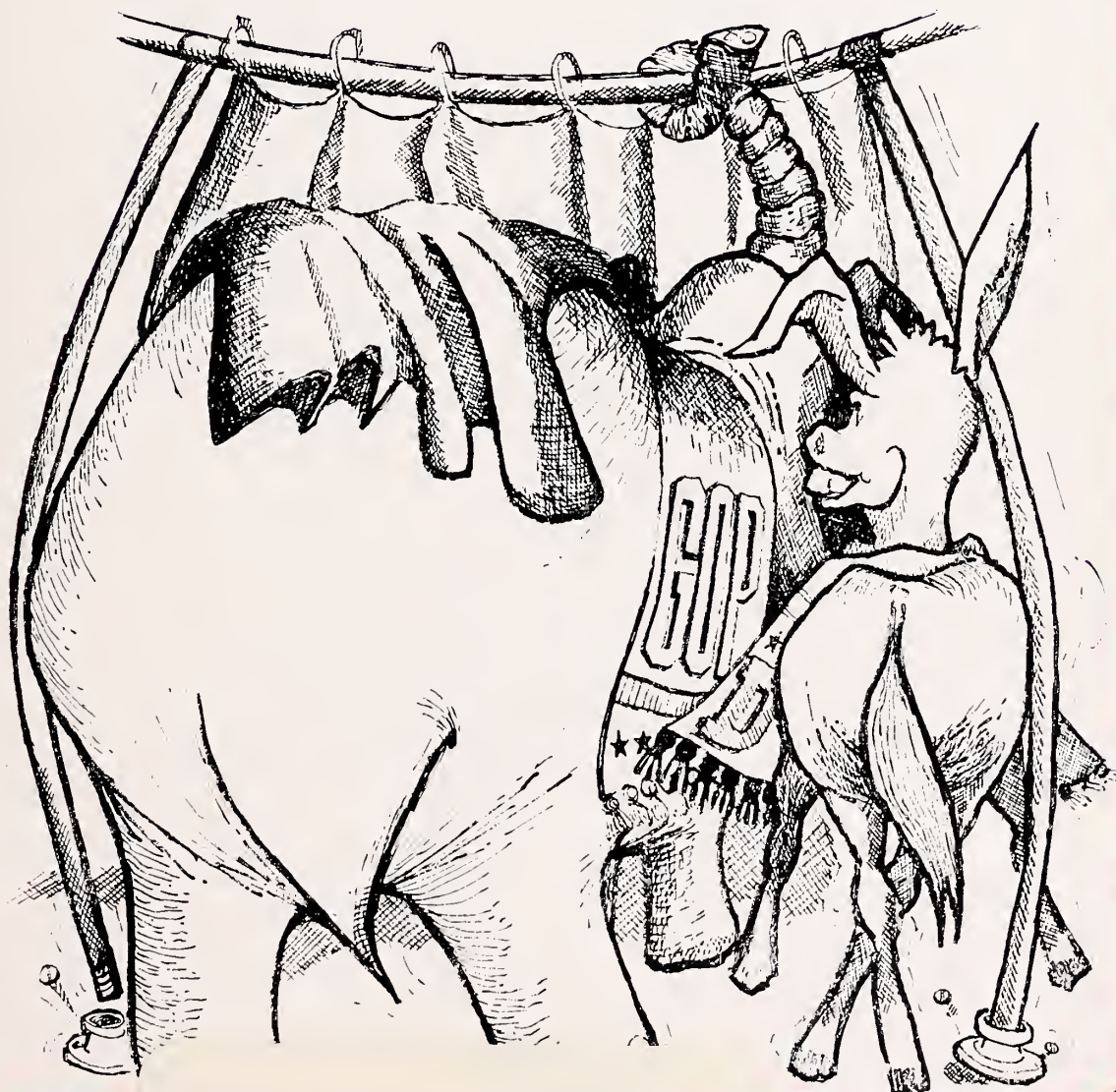
The new system, called Identi-Code™, consists of a combination of one letter and two figures which specify the form of the medication and its name and formula when reference is made to a Lilly code index. The code booklet is being distributed to physicians, dentists, pharmacists, nurses, law enforcement agents, poison-control experts, and others who deal with medical emergencies.

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Illustration by John Watt, Atlanta.



only one in the morning 

and one in the evening 



# EVALUATION OF THE CYANOTIC INFANT WITH SPECIAL REFERENCE TO CARDIOVASCULAR ABNORMALITIES

Gordon M. Folger, Jr., M.D., *Augusta*

- These infants, if diagnosed and treated early, are frequently amenable to life saving palliative surgery.

THE CYANOTIC INFANT in the newborn nursery or his slightly older neonate counterpart commonly confronts the physician caring for him with a complex problem. Initially the problem usually resolves itself into the facet of true ("central") cyanosis versus one of a number of conditions causing skin discoloration or peripheral cyanosis often having little meaning. Once ascertained as being clinically significant, a second problem arises: the cause of the cyanosis.

## Etiology Apparent

Occasionally, the etiology of the problem is readily apparent from the physical examination and routine studies. Thus newborns having hyaline membrane disease are usually prematures who have begun to have rapid, labored respiration shortly following birth.<sup>1, 2, 3</sup> Indeed, if normal respirations have been observed for longer periods than six or eight hours after birth, the infant should not be considered to have hyaline membrane disease.<sup>4</sup> Air exchange may be poor and inspiratory retractions marked. The chest radiograms, in addition to ruling out other causes of respiratory distress, reveal a reticular "ground glass" appearance in the lung fields. Numerous other conditions may be apparent as the cause of neonatal cyanosis. Thus, diaphragmatic hernia may be diagnosed from the examination and the radiographic appearance of abdominal contents in the chest. Atelectasis, congenital lobar emphysema, and pneumothorax are usually readily recognized. Trained nursery personnel will recognize

the depressed, cyanotic infant with central nervous system injury or infection.

The cause of transient cyanosis in the stressed newborn has been well documented by animal studies of Dawes<sup>5</sup> and the findings of Lucas<sup>6</sup> in humans. Normally, pulmonary vascular resistance is systemic or above at birth declining rapidly in the first minutes following birth, due to the increase in the pulmonary oxygenation of the blood.<sup>8</sup> With this phenomenon, the normally occurring antenatal right to left shunt diminishes so that no more than 15% to 20% of the cardiac out-put is shunted.<sup>4</sup> Although this figure exceeds the minimum considered to be detectable,<sup>7</sup> cyanosis is usually absent. Hypoxia due to many of the previously stated causes often results in the maintenance of pulmonary arteriolar constriction and persistence of elevated pulmonary vascular resistance with resultant pulmonary hypertension. When this occurs, the right to left shunts present though the foramen ovale, and ductus arteriosus are perpetuated resulting in systemic hypoxia and clinical cyanosis.

## Entity Described

An entity recently described by Danilowcz and associates and also encountered in our laboratory is a transient type of peripheral pulmonary arterial stenosis occurring in newborns.<sup>9</sup> Such infants may have elevated pulmonary vascular resistance and suffer pulmonary hypoperfusion with resultant hypoxia and cyanosis. One such child, recently studied by us at four hours of age, was deeply cyanotic. Following catheterization and angiography, she improved rapidly and by 12 hours of age was completely acyanotic. The angiogram revealed rapid tapering of the peripheral vessels with absence of

*From the Department of Pediatrics and the Hemodynamic Research Unit of the Medical College of Georgia.*

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THE CYANOTIC INFANT / Folger

any detectable opacification distal to the central pulmonary arteries.

Patients in the preceding categories often have some form of definitive therapy instituted shortly following recognition. The group of patients particularly to be considered in this report often mimic certain of the above mentioned, especially the infant with respiratory distress. These infants may go unrecognized for long periods of time, are often difficult to completely diagnose clinically, may appear so well, excepting the presence of cyanosis that they are considered stable, or, to the contrary, may appear so hopelessly ill that little more than supportive measures which often fail are employed. These children are those with cyanotic congenital heart disease. The remainder of this report is concerned with their initial recognition, their diagnosis and management and their treatment and ultimate fate.

Incidence

Cyanotic malformations contribute about one-third of all congenital cardiac anomalies.<sup>10, 11</sup> This, in itself, may be surprising; more startling, however, is the small number of these individuals who survive infancy. Recent studies have indicated that approxi-

mately 10% of all infants with cyanotic congenital heart disease may be expected to live to their first birthday.<sup>12</sup> Individually, certain types of these malformations have a significantly better prognosis than do others. Thus, tetralogy of Fallot is a surprisingly well tolerated defect, whereas transposition of the great vessels is usually very poorly tolerated. In view of such an overall poor outlook for these patients, it is mandatory that they be evaluated both early and completely. As a group and individually, they are to be considered as emergencies requiring early diagnosis and management. The older infant with later onset of cyanosis, in our experience, presents less of a problem and can often be managed by diligent, close follow-up with further evaluation when indicated. It should be emphasized that depth of cyanosis is often mistakenly used as a guide to the severity of the lesion. The newborn is often able to maintain pulmonary blood flow, utilizing patency of the ductus arteriosus, in sufficient quantity to minimize apparent cyanosis, though this is generally a transient mechanism. Cyanosis is usually not readily apparent at oxygen saturations above 75%. The hemoglobin level, often low in the older neonate, is an additional significant factor in the detection of cyanosis.<sup>13</sup> Indeed, the slightly cyanotic neonate may be severely hypoxic.

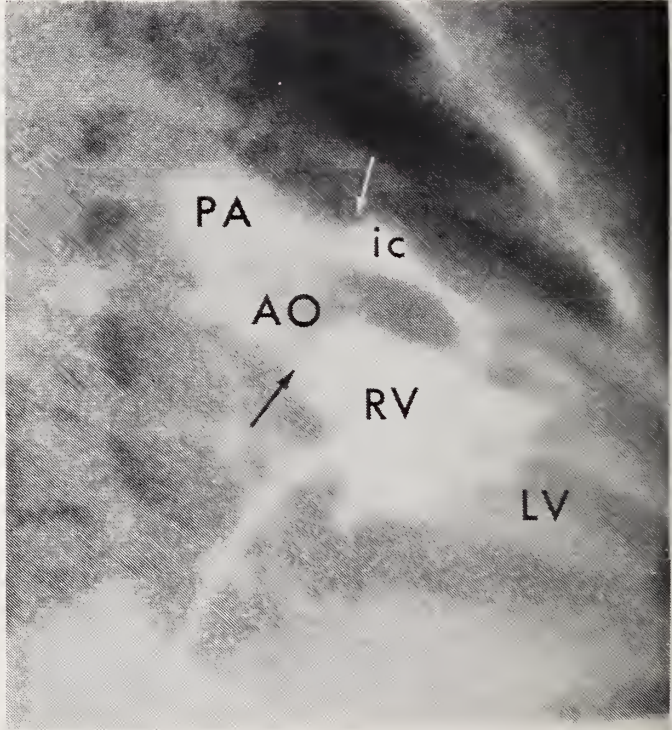
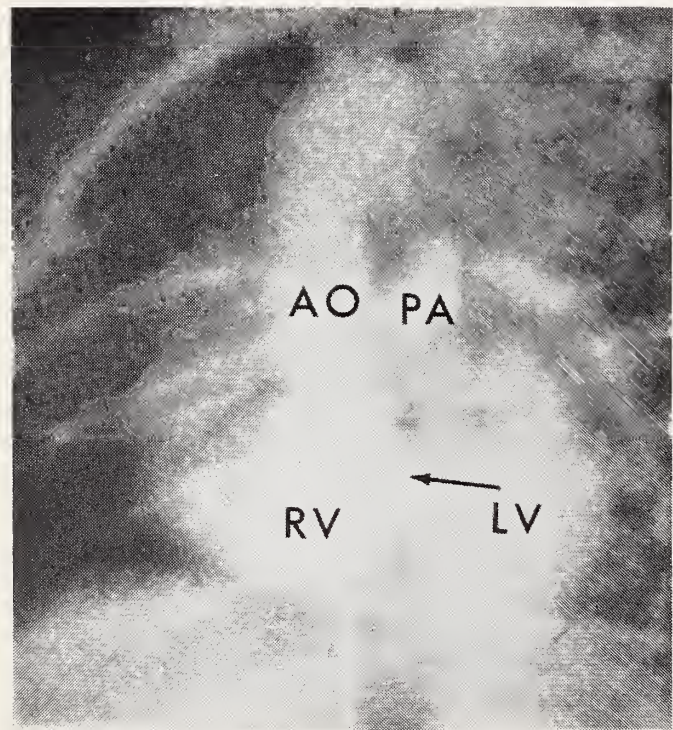


FIGURE 1

Single cineangiographic frames. Tetralogy of Fallot, right ventricular injection of opaque material.

(a) Left anterior oblique projection. The aorta (AO) and pulmonary artery (PA) are simultaneously opacified from the right ventricle (RV). The ventricular septal defect is indicated by the arrow. The left ventricle (LV) is less well opacified.

(b) Right anterior oblique projection. The right ventricle is opacified, whereas the left ventricle has not yet received blood containing opaque medium. The aorta and pulmonary artery are simultaneously opacified. The infundibular chamber (i.c.) is seen below the domed, stenotic pulmonary valve (white arrow) and the large non-opacified crista supraventricularis which constitutes the infundibular stenosis. The aortic valve is indicated by the black arrow.



In considering the individual defects, a number of general classifications may be employed. Grouping the malformations by the level at which the shunt occurs, with further subdivisions depending on the presence or absence of pulmonic stenosis, allows for both anatomic and physiologic descriptions. Thus, the term pretricuspid shunting is applied to defects in which the major right to left shunt occurs prior to the right ventricle as in tricuspid atresia and post tricuspid shunting as that which occurs at ventricular or great vessel level.

*Group I: Post tricuspid right to left shunt with pulmonary stenosis.*

The *tetralogy of Fallot* is the ideal example of malformations of this group (Figure 1). As classically described,<sup>14</sup> the existence of a large ventricular septal defect with severe pulmonary stenosis which may be infundibular or valvular comprise the malformation. The resultant systemic right ventricular pressure and predominant right to left shunt to the overriding aorta are the essential physiologic consequences of the altered anatomy. Because of the adequacy of both right and left ventricular outflow, even in the presence of severe cyanosis, the heart seldom enlarges and rarely is congestive heart failure encountered.<sup>15</sup> A number of cases representing atypical forms of the tetralogy of Fallot have been reported<sup>16, 22</sup> many of which result in alteration in the clinical picture and may complicate therapy. It

is not the purpose of this discussion to describe such variables which nevertheless must be considered prior to surgical intervention.

Patients suffering with the tetralogy of Fallot generally manifest cyanosis in the first year of life and may do so in the neonatal period. When it presents, it is indicative of increasing hypoxia which in many instances leads rapidly to deep cyanosis with cyanotic spells being a severe and life threatening result. These patients should be fully evaluated when cyanosis appears so that a therapeutic plan may be outlined and carried out when necessary. As with all the lesions under discussion, it is better to evaluate these patients when they are in good condition than to wait for deterioration, thus increasing their risk at diagnostic study. The recent review by Coleman<sup>12</sup> has indicated that of all the cyanotic defects, tetralogy of Fallot alone was the most commonly encountered defect and did not cause a single death. This should not be construed as showing this defect as a benign one, but more to demonstrate the efficacy of proper and prompt management.

The surgical management of these infants usually consists of a shunting procedure designed to increase the pulmonary blood flow although in selected cases, pulmonary valvulotomy<sup>23</sup> may be quite adequate. The anastomatic procedures generally preferred are those between a systemic artery and one of the pulmonary arteries as described by Blalock and Tausig<sup>24</sup> and Potts.<sup>25</sup> Superior vena cava to right pul-

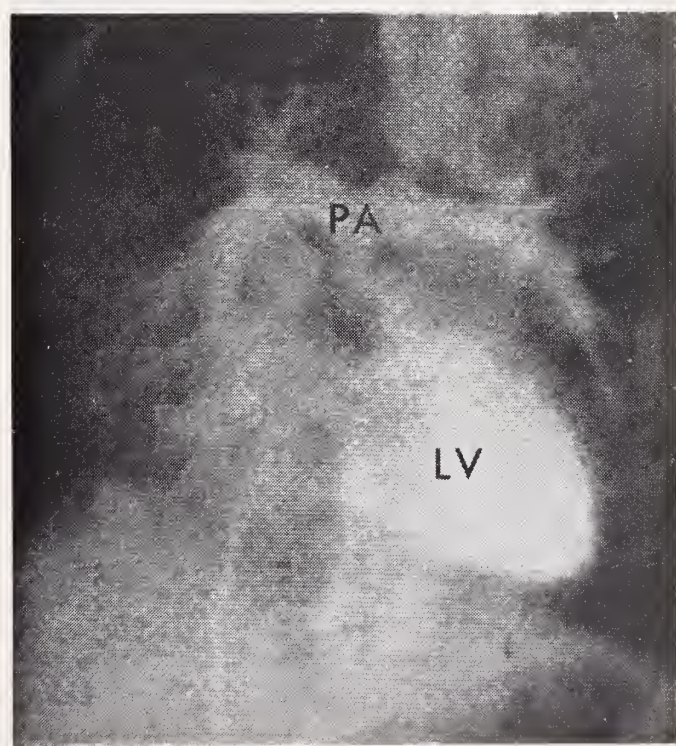
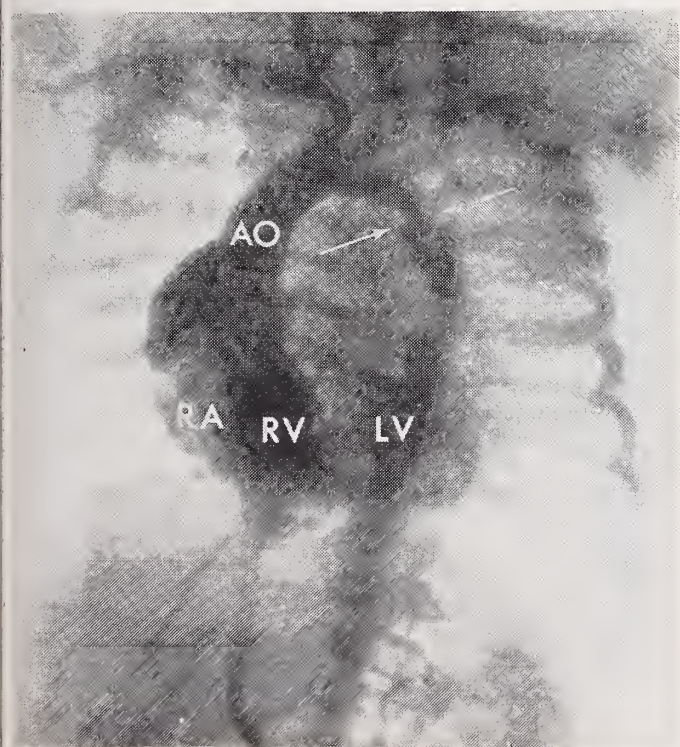


FIGURE 2

Transposition of great vessels.

(a) Venous angiogram. The aorta (AO) arises entirely from the right ventricle (RV) receiving blood directly from the systemic venous return. Minimal shunting of blood to the left ventricle (LV) by way of a ventricular septal defect. A coarctation of the aorta is seen (arrows).

(b) Single cineangiogram. Injection of opaque material into the left ventricle (LV). The pulmonary artery (PA) is opacified in the usual position of the aorta. No shunting to the right heart structures or aorta is seen.



## THE CYANOTIC INFANT / Folger

monary artery anastomosis<sup>26</sup> also may be employed. The overall surgical risk with such procedures is presently low<sup>27</sup> and the benefit to the patient is great and often lifesaving.

### Difficulty in Diagnosis

Emphasis must be made of the difficulties in the clinical diagnosis of tetralogy of Fallot in neonates. Thus, although one can usually depend on the characteristic electrocardiogram revealing right axis deviation and right ventricular hypertrophy, the occasional electrocardiogram in the infant with this abnormality may be deceptively normal as it may in several of the malformations to follow. Also, the assessment of heart size and pulmonary vascularity in this age group may be less reliable than with older patients. Moreover, as with all congenital cardiac defects, no matter how severe, the infant so affected may be without murmurs.

*Transposition of the great vessels with pulmonic stenosis*, although included in this group, in an anatomic sense does not represent shunting of blood at all (Figure 2). Because of the reversal of the great arterial origins, strictly speaking, the cyanosis is due to a normal progression of blood flow with the exception that the lungs are completely or to a large extent, bypassed. Indeed, the greater the degree of shunting, the less intense the cyanosis will be. To illustrate this fact, one need only consider the benefit afforded such patients by the surgical creation of an atrial septal defect.<sup>28</sup>

In considering the malformation of transposition of the great vessels, it is not possible to discuss one entity with consistent physical, electrocardiographic and radiographic findings so dependent are these findings on the intracardiac malformations which often coexist with the malalignment of the arteries.<sup>29, 30</sup> As with the tetralogy of Fallot, it is not the purpose of this report to review in detail the intracardiac variations of this malformation. In general, transposition of the great vessels with pulmonic stenosis should be considered as a life threatening lesion, producing severe cyanosis early in the neonatal period. Hypoxia and the development of congestive cardiac failure with rapid deterioration leading to early death often result.

### Condition Deceptive

Not infrequently, the newborn suffering with transposition of the great vessels with the exception of cyanosis may appear to be in deceptively good condition. The infant, statistically most often a male, is usually of normal birth size and is often large.<sup>31</sup> No abnormalities of his heart or lungs other than cyanosis may be detected, the radiographic appearance of

the chest may be unremarkable and the electrocardiogram may be within normal limits. If the precarious condition of such infants is not recognized, their condition may deteriorate, following discharge to the care of the mother, reaching the point of severe hypoxia, acidosis and intractable congestive heart failure. At this point, infants rarely survive the necessary diagnostic studies and palliative surgery.

More frequently on examination of the cyanotic child with transposition of the great vessels, the clinician will find a loud snapping second closure sound and a systolic murmur of varying degree. The electrocardiogram usually reveals a right axis deviation and the chest radiograms reveal a normal or moderately enlarged heart with a remarkably narrowed base imparting a somewhat "egg shaped" configuration to the cardiac silhouette. The pulmonary vascularity is usually normal or slightly reduced in appearance, although increase in the pulmonary vascular markings may be observed.

Treatment in this group of patients is primarily centered about the improvement in mixing between the two separate circulations within the heart. This may be accomplished satisfactorily in many instances by the creation of an atrial septal defect.<sup>28</sup> The results of this procedure are often dramatic, although the child usually remains cyanotic. If the pulmonary stenosis is severe, it may also be necessary to perform one of the anastomotic procedures previously described. The results of such treatment are extremely gratifying and, as with tetralogy of Fallot, may increase longevity so that a totally corrective procedure may be performed.<sup>32</sup>

### *Group II: Post tricuspid right to left shunt without pulmonary stenosis.*

*Transposition of the great vessels without pulmonary stenosis* is the only common abnormality in this group. As previously mentioned, the clinical manifestations of this malformation depend almost entirely on the absence or presence and degree of associated cardiac abnormalities.

As might be expected, the most severely involved of these infants are those without significant malformations, and thus no mixing of blood between the transposed systemic and pulmonary circuits. Infants so involved survive on only what shunting can occur through the anatomically normal channels, i.e. the foramen ovale and the ductus arteriosus. Collapse, primarily due to hypoxia occurs rapidly. Emergency evaluation and surgery is imperative, for these children at present are the most amenable to a totally corrective procedure. Those infants with a significant defect in the interventricular septum tend to survive for the longest periods of time obviously



due to a more effective mixing of pulmonary and systemic blood. Often, however, this mixing is inadequate due either to streaming of the blood or to a less than adequate sized defect and deterioration due to hypoxia, congestive cardiac failure, and marked increase in pulmonary blood flow rapidly supervenes. In such instances, treatment consists in increasing mixing between the systemic and pulmonary circuits and usually reducing the blood flow to the lungs by surgically creating a pulmonary stenosis (pulmonary banding).<sup>33</sup> Infants so treated may be remarkably improved.

*Group III: Pretricuspid right to left shunt with pulmonary stenosis.*

The defect typically illustrative of this group of malformations is *tricuspid atresia* (Figure 3). The altered physiology with this malformation differs significantly from that of the previously described anomalies in several ways. The most obvious difference is the obligatory shunt across the atrial septum with all the blood to the ventricular complex crossing the mitral valve. Thus mixing of the blood from the two circuits is virtually complete as it enters the left ventricle, the degree depending on the amount of pulmonary blood flow and on the size of the atrial septal communication. In order for the portion of

this blood destined for oxygenation to reach the pulmonary bed, there must not only be a right ventricular outlet, but there must be a defect in the ventricular septum sizable enough to allow blood to be transmitted to the right ventricle in adequate quantities. In general, the clinical picture is governed by the nature of these associated anomalies.

### Variation Occurs

As with the previously mentioned abnormalities, a significant degree of anatomic variation occurs with this malformation which varies from the alteration in intracardiac anatomy mentioned above to such major anatomic differences as a coexistent transposition of the great vessels.<sup>29</sup> Such variations notwithstanding, the diagnosis clinically is usually indicated by the combination of a cyanotic infant with the electrocardiographic findings of leftward deviation of the QRS axis and distinct reduction in the anteriorly directed forces in the precordial leads. Cyanosis is usually intense. The radiographic findings are variable but in general, the heart is normal in size and may closely resemble the cardiac silhouette found in tetralogy of Fallot.<sup>30</sup> The lung fields are hypovascular or normal in appearance.

As with other malformations with severe pulmonary stenosis, these individuals are often in precarious

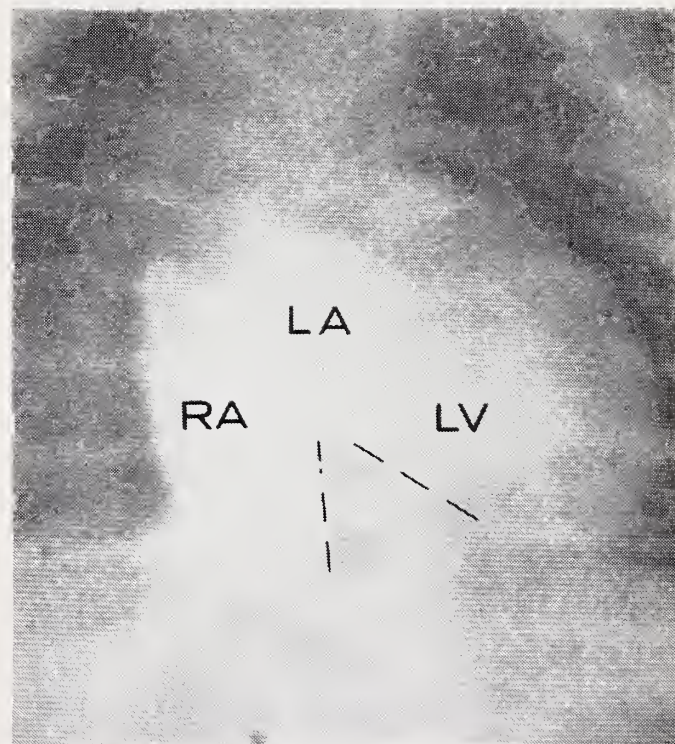
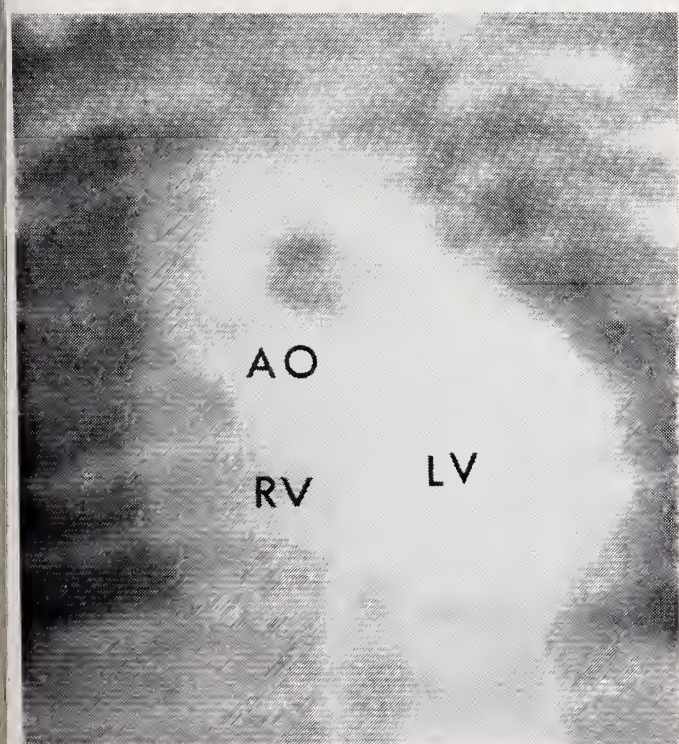


FIGURE 3

Single cineangiographic frames. Tricuspid atresia with pulmonary atresia.

(a) Injection of opaque material into left ventricle employing left anterior oblique projection. The enlarged left ventricle (LV) gives origin to the aorta (AO). The diminutive anteriorly located right ventricle (RV) contains no opaque medium.

(b) Injection of opaque material into the right atrium employing the frontal projection. Opacification of the right atrium (RA), left atrium (LA) and left ventricle is apparent. A triangular area (broken lines) which remains unopacified represents the diminutive right ventricle which has received no blood via the tricuspid valve. As seen, this area closely corresponds to the same area as in (a).



## THE CYANOTIC INFANT / Folger

condition from severe hypoxia early in life. Although, at present, the nature of this malformation precludes surgical correction, accurate anatomic diagnosis is none the less mandatory. The results of palliative surgery for the improvement of pulmonary blood flow is often dramatic and most rewarding. Not only is the patient himself often considerably improved and much less of a care problem, but the parents also may be relieved of the burden of the patient's chronic disabilities or fear of his impending death.

Closely related physiologically to tricuspid atresia is the entity of *pure valvular pulmonic stenosis or atresia with intact ventricular septum* (Figure 4). However, the right to left shunt at atrial level occurs in the presence of a functional tricuspid valve and right ventricle due to the difficulty or inability of the ventricle to empty itself of blood. The depth of cyanosis and to significant degree, the condition of the patient is dependent on the size of the interatrial communication; in the absence of such communications, the child, though extremely ill, may be entirely acyanotic.

### Clinical Appearance

Not infrequently, the clinical appearance of this infant is that of moderate cyanosis and signs of early congestive heart failure as evidenced by facial edema and enlargement of the liver. A systolic murmur is usually present,<sup>34</sup> although this may be absent in

the neonatal period or in the presence of heart failure. In contradistinction to the other defects herein described, the second closure sound is classically soft and the pulmonic component absent. With worsening of this condition, the cyanosis may deepen rapidly and true hypoxic episodes may supervene with the ever-present threat of death. The recent study by Luke<sup>34</sup> has commented on the error of postponing definitive therapy while awaiting clinical improvement with medical management in such cases.

The electrocardiogram usually shows severe right ventricular hypertrophy and often right atrial hypertrophy. However, in its absence, one cannot completely eliminate the diagnosis in an occasional patient, especially with pulmonary atresia, in whom the electrocardiogram may resemble tricuspid atresia.<sup>35</sup> The radiograms of the heart regularly reveal cardiomegaly with a globular cardiac silhouette.<sup>34</sup> Hypovascularity of the lungs is an important finding, but the pulmonary vessels may appear deceptively normal.

Rapid deterioration and collapse is a constant threat. As with all the cyanotic malformations, early evaluation employing cardiac catheterization and angiography is essential in the management of these patients. The anatomy must be outlined as exactly as is possible and the physiologic derangement accurately determined. The treatment is pulmonary valvulotomy.<sup>23</sup> Anastomotic procedures in this type

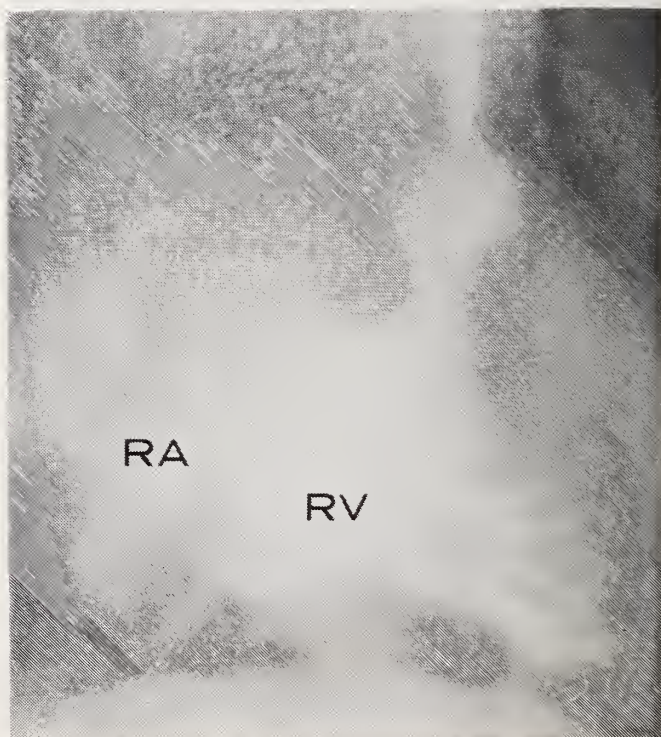
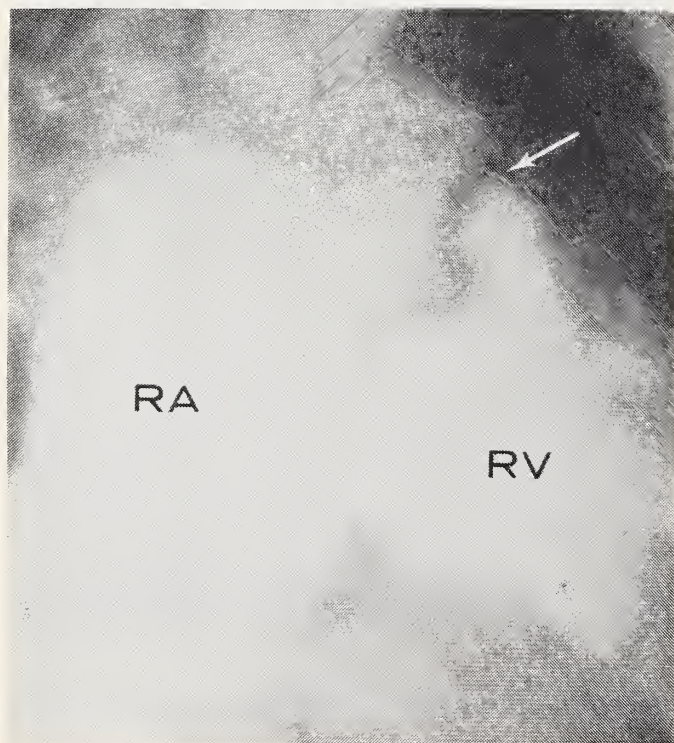


FIGURE 4

Single cineangiographic frames. Injection of opaque material into the right ventricle. Right anterior oblique projection.

(a) Pulmonary atresia. The right ventricle (RV) ends blindly in a domed, atretic pulmonary valve (arrow). Tricuspid regurgitation into the right atrium (RA) is present.

(b) Severe valvular pulmonary stenosis. Here a jet of opaque material is seen traversing the pulmonary valve. Regurgitation to the right atrium is again seen.



of patient are not indicated and, if performed, usually lead to cardiac failure and death.

The results of pulmonary valvulotomy are usually dramatic. Cardiac compensation is regained and cyanosis disappears promptly. The surgery, however, may be only palliative with a more definitive procedure required at a later date.

*Group IV: Pretricuspid right to left shunt without pulmonary stenosis.*

*Tricuspid atresia* may occur as a defect causing increase in pulmonary blood flow. When this occurs, transposition of the great vessels is usually present (Figure 5); only rarely has normal great arterial origin been reported with tricuspid atresia and increase blood flow to the lungs.<sup>36</sup>

Patients with this malformation are less cyanotic than their counterparts with pulmonic stenosis and frequently manifest intractable pulmonary edema.<sup>37</sup> Thus, they may be difficult to differentiate from truncus arteriosus, transposition of the great vessels without pulmonary stenosis and ventricular septal defect with elevated pulmonary arterial pressure and congestive heart failure. In our experience,<sup>37</sup> although the malformation may be suspected from the electrocardiographic picture and the radiograms of the chest, the diagnosis may only be made at the time of cardiac catheterization and angiography.

The outlook for such patients without a surgical procedure to reduce the pulmonary blood flow is dismal. With surgery of this type, some patients may be improved but the overall prospect is poorer for this group of patients than any of those under discussion.

## Conclusion

This review of the more common cyanotic defects, according to a recent survey<sup>10</sup> has accounted for approximately 30% of all congenital cardiac abnormalities but represents the cause for slightly greater than 60% of the deaths in the entire group during the neonatal period. It must be emphasized once again, that this group of infants, if diagnosed and treated early before signs of severe hypoxia or cardiac decompensation occur, is amenable to a great extent to life-saving palliative surgery. Many infants so treated will become future candidates for total correction of their defects.

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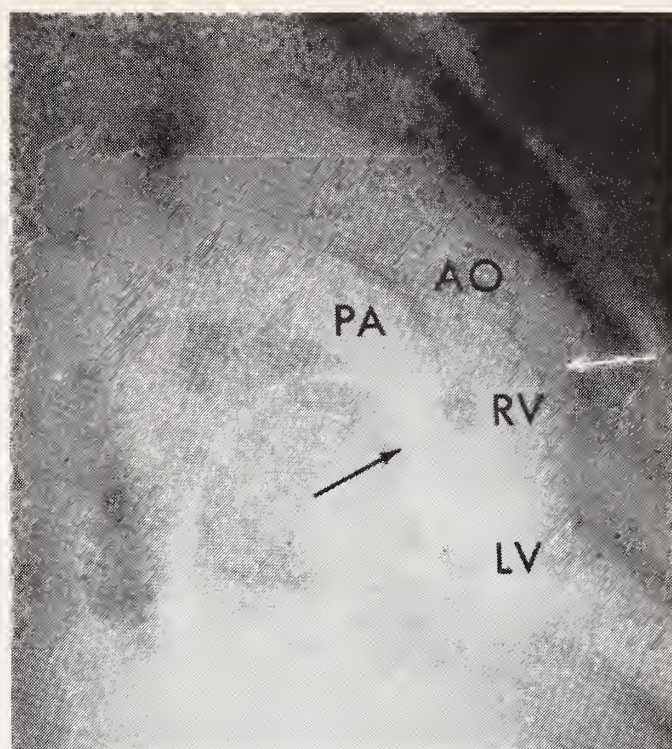


FIGURE 5

Single cineangiocardigraphic frame in right anterior oblique projection. Tricuspid atresia, transposition of the great vessels, slight pulmonic stenosis. Injection of opaque material into left ventricle. The left ventricle (LV) comprises the major portion of the heart. The right ventricle (RV) is reduced to a diminutive outflow chamber leading to the anteriorly positioned aorta (AO). As is usual with transposition of the great vessels, the pulmonary artery (PA) lies posterior to the aorta with its valve (dark arrow) on a lower plane than the aortic valve (white arrow).

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## THE CYANOTIC INFANT / Folger

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The Medical Association of Georgia, in cooperation with Mead Johnson Laboratories, takes pleasure in announcing the AESCULAPIUS AWARD, to be presented to the author of the most outstanding scientific exhibit shown at the 1967 Annual Meeting.

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Atlanta, Georgia, April 30-May 1-2, 1967

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# PRIMARY PULMONARY LYMPHOCYTIC LYMPHOMA

Agatha M. Thrash, M.D. and Robert H. Vaughan, M.D., *Columbus*

- Surgical excision, chemotherapy and radiation have been effective in the therapy of this rare neoplasm.

**T**HE RARITY of primary and localized pulmonary lymphomas brings us to report the following case. Several interesting diagnostic and therapeutic problems were encountered which are discussed.

## Case Report

R.L., W.M. 49 years old, hospital case No. A-19004, was admitted to St. Francis Hospital on 1/21/63 for diagnostic studies and a probable right thoracotomy because of a lesion discovered during a routine physical examination in his right upper lung field. He had no specific symptoms relating to the chest and his only complaint was of easy fatigue and a feeling of being "run down." There were, in addition to the parenchymal lung lesion, two areas of pleural thickening, one in each chest, considered by the radiologist to represent pleural neoplasm. The presence of these bilateral pleural tumors raised the question of the advisability of thoracotomy, since the process appeared already inoperable, if it were a neoplasm.

His hemoglobin on admission was 15.9 gms., WBC 7,050, with 3 bands, 75 neutrophils, 18 lymphocytes and 4 monocytes. A bronchoscopic examination was done on 1/22/63; no specific endobronchial disease could be determined. Since a definite diagnosis could not be made from the bronchoscopy, it was felt that a thoracotomy was mandatory. On 1/24/63 his right chest was explored and a radical right upper lobectomy was performed for a lesion measuring 2 x 2 x 2½ inches. It was located in the posterior division of the right upper lobe with an additional lesion somewhat smaller than this located nearer to the hilum in the parenchyma of the RUL. The pleural plaques seen on the x-rays were found to be dense, fibrotic thickenings having no definite relationship to the major pathology in the parenchyma. The entire palpable pathology was removed from the

right hemithorax. He tolerated his operative period quite well and had an uneventful convalescence.

The specimen included the right upper lobe, the plaques of pleura, hilar lymph nodes, and a portion of bronchial stump. The pulmonary lobe presented two distinct areas of firm induration in the parenchyma, one beneath the pleura, and the second near the hilum. Each mass, on cross section, faded into the surrounding pulmonary tissue by tiny granular nodules, but consolidated in the central area to a smooth, pinkish-tan, homogeneous mass. The central areas were quite firm. The surrounding pulmonary parenchyma showed some atelectasis. Several bronchi were obstructed by gelatinous, mucoid material.

Microscopically the sections of the two masses were similar, except that the mass near the pleura was composed of a solid mass of lymphocytes in the central areas with tiny nodules developing near the



FIGURE 1

The gross photograph represents the cross section of the right upper lobe. The pleural surface is visible on the upper portion of the specimen. The largest consolidation of the lymphoma is seen in the center of the photograph. There is a fading-off of the tumor into the adjacent atelectatic lung. Anthracotic pulmonary connective tissue is preserved throughout the tumor, indicating the infiltrative nature of the tumor.



## LYMPHOMA / Thrash and Vaughan

periphery and extending into the surrounding pulmonary parenchyma for several millimeters. The mass near the hilum was composed of small groups of lymphocytes, apparently in an earlier stage of development than the sub-pleural nodule. The lymphocytes were closely packed and presented a fairly uniform appearance, occasionally showing an attempt at follicle formation. The infiltrates extended along bronchi and the septa of the pulmonary tissue. The submucosal areas of the bronchi were infiltrated, but in no place was there ulceration of the bronchial mucosa. The thickened pleural plaques were laminated, hypocellular connective tissue showing no evidence of malignancy.

Although the hilar lymph nodes were histologically free of evidence of lymphoma, and there were no radiological or palpatory indications of the continued presence of lymphoma, it was felt that additional treatment was indicated. In his post-operative period he received a course of nitrogen mustard therapy and in the later part of February he received a course of Tele-roentgen (Cobalt) therapy. Subsequently the patient has had two additional courses of nitrogen mustard. At the present time his chest film is unremarkable and he is working full time as a lather, essentially asymptomatic.

### Discussion

Histologically these tumors must be differentiated from pseudolymphomatous infiltration of the lung. The main differential point is a lack of follicles in the true lymphoma group. It has been questioned by the anatomists whether or not actual lymphoid tissue exists in the lungs proper, away from the mediastinum and hilar areas. Yet, the occasional appearance of a case of primary lung lymphoma seems to prove its presence. The patient may present clinically with symptoms of pneumonia and the x-rays may not distinguish the infiltrate of the neoplasm from that of an infectious pneumonic process.

As late as 1957 only 21 cases had been reported according to Dr. Hewitt Rose of St. Louis.<sup>1</sup> In 1956



FIGURE 2

The section was prepared on the edge of the large lymphoma mass. Note the small, rounded nodules of closely packed lymphocytes in the central area, and the large mass beginning in the right lower quadrant of the photograph. Many alveolar septa are visible between the portions of the tumor.

Drs. Jack Cooley, John R. McDonald and O. Theron Clagett of Rochester, Minnesota,<sup>2</sup> reported nine cases. The symptoms can be bizarre and may simulate unresolved pneumonia, primary bronchogenic carcinoma, or obstructive collapse. Or, as in the case reported in this article, the lesion may be discovered on routine physical examination.

### Summary

A case is presented of primary lymphocytic lymphoma of the lung. The patient presented with symptoms of pneumonia. The x-rays showed infiltrative masses in the right lung, and pleural plaques in both lungs (which proved to be fibrous thickening). The subpleural mass was considered to be the primary tumor; however, the removed specimen revealed a second nodule near the hilum. An intensive search has revealed no additional evidence of lymphoma in the patient, and none has developed in the two years following initial workup.

St. Francis Hospital

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## REQUESTS FOR THE MENTAL HEALTH PAGE

In order to present articles that will be of value and interest to the physicians of Georgia, it is requested that questions or suggestions for subjects pertaining to Mental Health be submitted.

These subjects or questions will then be submitted to appropriate people throughout the state. It is felt that this might make the Mental Health

Page of more value to the physicians of Georgia. Please send your questions or subjects with your name and address to:

J. Kenneth McDonald, M.D.  
1445 Harper Street  
Augusta, Georgia 30902

# ULCERATIVE COLITIS— REVIEW AND SURGICAL ASPECTS

A. B. Conger, M.D. and S. A. Roddenbery, M.D., *Columbus*

- A review of all the cases of proven ulcerative colitis which have been admitted to either of the two hospitals in Columbus, Georgia, in the last fifteen years, with a detailed review of the cases which came to operation.

WE WANT to acquaint you with some of the things we learned from this review and from our treatment of some of these cases. We are definitely not going to recapitulate facts which presumably everybody knows about chronic ulcerative colitis, although one of the things we have learned is that nobody knows very much about it.

## Interesting Revelation

The most striking thing about this review is the small number of cases of ulcerative colitis in Columbus in 15 years, although it is a well-known fact that ulcerative colitis is much more common in the North than it is in the South.<sup>1</sup> We could find only 51 cases of documented ulcerative colitis admitted to either of the two hospitals here in the last 15 years.

FIGURE 1  
CASES OF ULCERATIVE COLITIS  
PROVEN BY X-RAY OR SIGMOIDOSCOPIC  
EXAMINATIONS ADMITTED TO HOSPITALS IN  
COLUMBUS FROM JANUARY 1950  
TO JANUARY 1965  
TOTAL NUMBER = 51

The next impressive finding in this review was that a number of cases of amebic dysentery are misdiagnosed as ulcerative colitis. In our own practice, we have had four patients that we originally thought had ulcerative colitis who responded quite well to treatment for amebic dysentery. In this review, we found two other cases which had been admitted to the hospital several times for ulcerative colitis which eventually turned out to be amebic dysentery. This has prompted us to feel that at some time in the course of treatment of every case of ulcerative

colitis, a full treatment for amebic dysentery should be given whether or not this specific diagnosis has been made.

FIGURE 2  
6 CASES ORIGINALLY DIAGNOSED  
AS ULCERATIVE COLITIS, CURED  
BY TREATMENT FOR AMEBIC DYSENTERY

Another thing which struck us was the variety of symptomatology which is called ulcerative colitis. Practically all of these patients had bloody diarrhea, but we were most impressed with the idea which is becoming prevalent that there are several varieties of ulcerative colitis and that so-called "segmental" ulcerative colitis is not the same disease as the ulcerative colitis which affects the entire bowel. There is a great deal of confusion about this and about the relationship of ulcerative colitis to regional enteritis. This is gradually being worked out.<sup>2</sup>

FIGURE 3  
IS "NON-SPECIFIC" ULCERATIVE COLITIS  
ONE DISEASE OR MANY DEPENDING ON AREA  
OF BOWEL INVOLVED AND ON SEVERITY?  
HOW RELATED TO REGIONAL ENTERITIS?

In our review, we found ulcerative colitis associated with many other gastrointestinal lesions. We feel this is worthy of mention. Fourteen of the 51 cases of ulcerative colitis had other lesions of the gastrointestinal tract. These ranged from peptic ulcers of the esophagus, stomach, and duodenum to regional enteritis, to carcinoma of the bile ducts. Some of these patients have been operated on for these "secondary" diseases. Consequently, we have learned to look for other lesions or at least not discount them when we run into a patient with ulcerative colitis.

Presented at the 112th Annual Session of the Medical Association of Georgia, May 8, 1966, Columbus, Georgia.



FIGURE 4  
14 OF 51 PATIENTS (28%)  
WITH ULCERATIVE COLITIS HAD  
OTHER LESIONS OF GASTROINTESTINAL  
TRACT, SOME OF WHICH REQUIRED SURGERY

In the treatment of ulcerative colitis, everybody agrees that medical therapy has greatly improved. In the acute, severe episodes, hospitalization with freedom from care and responsibility, diet, antibiotics, steroids, and generally good supportive therapy have given good results and have kept many of these patients going for as long as 35 years.

Another impressive thing about therapy, from the negative side, is that, in our opinion, ulcerative colitis is not a psychosomatic disease. Many of these patients have had psychotherapy and have been greatly benefited from this, but it does not seem to alter the course of ulcerative colitis.

And now we come to the interesting part of this paper for surgeons: When should you operate, what should you do, and what can you expect?

Reasons for Surgery

In this series of 51 cases, seven of the patients came to surgery for ulcerative colitis. This is about 14%, which is pretty much the average over the country in large reported series. All seven of these patients obviously failed to respond to intensive medical therapy, but, in addition, four of the seven had massive bleeding, two had chronic downhill courses, two had questionable carcinomatous changes, one had toxic dilatation of the colon, two had numerous fistulae, and two had almost complete obstruction.

FIGURE 5  
REASONS FOR SURGERY IN 7 PATIENTS  
(SEVERAL HAD MULTIPLE OPERATIONS)

MASSIVE BLEEDING .....	4 CASES
CARCINOMATOUS CHANGE .....	2 CASES
MULTIPLE FISTULAE .....	2 CASES
OBSTRUCTION .....	2 CASES
TOXIC DILATATION COLON .....	1 CASE
CHRONIC DOWNHILL COURSE ...	2 CASES

It is worth mentioning that it has proven very difficult for us to talk patients into having an ileostomy. It may be that our own feelings about ileostomies come through to the patient in that we wouldn't particularly want to have one ourselves. Anyway, of the seven patients which we are presenting here, five have ileostomies.

As regards what should be done at the time of surgery, most all authorities agree now that an ileostomy with a proctocolectomy is the procedure of choice except in patients with localized segmental disease and in critically ill, poor risk ones. However, we do want to emphasize the fact that the surgical care of these patients has to be individualized. Of the seven patients who we are presenting, none had a com-

bined ileostomy with proctocolectomy at one procedure. Four have had ileostomies followed later by a total proctocolectomy, one had a partial colectomy followed later by an ileostomy, one has had large portions of both small and large bowel removed without an ileostomy, and the last has had a segmental resection of the colon with an end to end anastomosis.

FIGURE 6  
SURGICAL PROCEDURES DONE ON 7 PATIENTS  
ILEOSTOMY FOLLOWED LATER BY  
PROCTOCOLECTOMY ..... 4 CASES  
PARTIAL COLECTOMY FOLLOWED BY  
ILEOSTOMY ..... 1 CASE  
RESECTION SMALL AND LARGE BOWEL  
WITHOUT ILEOSTOMY ..... 1 CASE  
SEGMENTAL RESECTION COLON WITHOUT  
ILEOSTOMY ..... 1 CASE

What can you expect following surgery?

In the first place, if you are lucky and have good internists helping you, you can expect a relatively low mortality. Of the seven patients we are presenting, none died, although some of them were very ill for long periods of time.

Secondly, we believe that you can expect a happier patient in better physical condition following surgery than he was before surgery. As a matter of fact, all seven of the patients we are showing are functioning well in their jobs or in their house work, and some of them are having to be a little careful about their weight. One has had a baby since her surgery.

Third, you can expect complications from the ileostomy itself.<sup>3</sup> We have been spared some of the worse complications from ileostomy, but out of four patients on whom we operated, two have required revision of the ileostomy, and most large series of cases



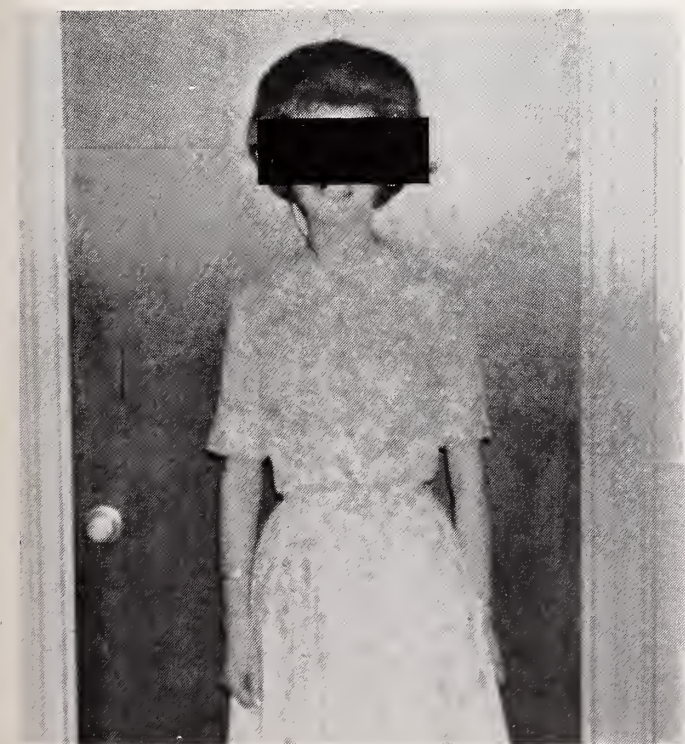
Case Number 1



report that some 50% of ileostomy patients eventually return to surgery for ileostomy disfunction, intestinal obstruction, or perineal repair.

Following are the seven patients with ulcerative colitis who have been hospitalized with this disease in Columbus, Georgia, and who have required surgery. As has been mentioned, four of these seven are patients of the authors. We are indebted to Dr. W. G. Love for allowing us to present two of his patients, and we are indebted to some unknown Veterans Administration Hospital surgeon for the seventh case. We keep in pretty close contact with most of these patients and had six of them come to our office recently so that we could take their picture for this presentation.

*Case No. 1* is a picture of Mr. M. T. who is a forty-six-year old male. Ten years ago, he had a subtotal gastrectomy and vagotomy for a severe duodenal ulcer. Three years later, he had an ileostomy for severe bleeding from his ulcerative colitis. Eight months after this, a total colectomy was done and since that time, he has had three other surgical procedures, one being a revision of the ileostomy, another for stenosis of the gastro-enterostomy, and the last a few days ago for chronic obstruction due to volvulus. This patient emphasizes the multiplicity of diseases that some of these patients seem to have and the trouble they get into.



Case Number 2

*Case No. 2* is my secretary who filled in for a lady who is now living in Texas. She is a lucky person who had segmental ulcerative colitis and who was totally cured by Dr. W. G. Love with a resection of the distal descending and sigmoid colon and an

end to end anastomosis. The question is raised as to whether or not this is the same disease as the disease requiring a total colectomy.



Case Number 3

*Case No. 3* is now forty-three years old. She was operated on three times by an osteopathic surgeon for rectal fistulae. She developed cellulitis of the anus and eventually went to Dr. Love. Her ulcerative colitis became so severe that an ileostomy was done some six years ago followed by a total proctocolectomy done in two stages. This case does illustrate one



Case Number 4

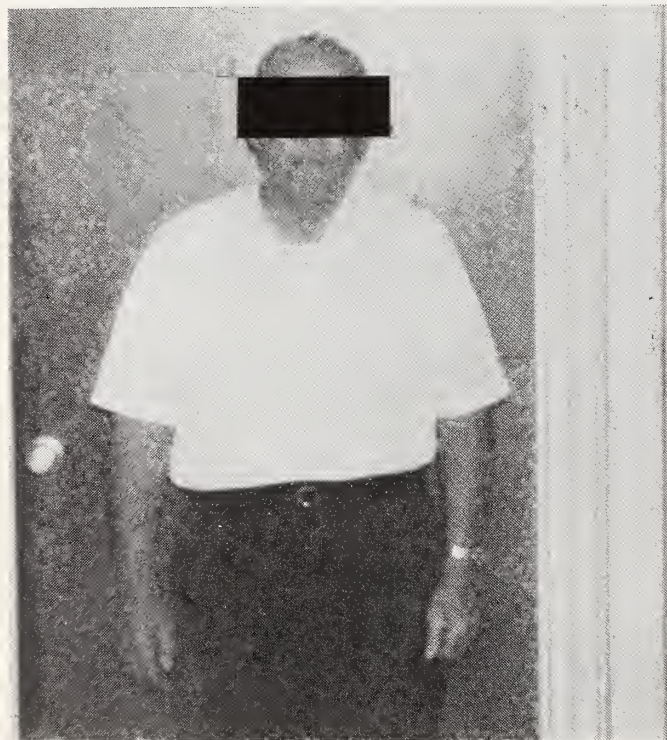


## COLITIS / Conger and Roddenbery

of the dangers of operating on patients with ulcerative colitis for things such as hemorrhoids, fissures, or fistulae.

*Case No. 4* is an interesting patient now thirty-six years old who first had trouble in high school. At the age of 24 a right colectomy and terminal ileectomy were done for obstructive regional enteritis. She began to bleed severely from her colon and ulcerative colitis was diagnosed, and an ileostomy was eventually performed. Because of questionable carcinomatous changes, a partial colectomy has been done, but she has refused to have all of her colon removed.

Does this woman have true ulcerative colitis as our pathologist thinks, or is this ileocolitis of the "Crohn" disease type?



Case Number 5

*Case No. 5* is now forty-nine years old. We did a hemorrhoidectomy on him about six years ago and following this he continued to bleed from his rectum, although he healed well from his surgery. Ulcerative proctitis was diagnosed and eventually, because of severe hemorrhage, an ileostomy was done. He is the only patient we have who developed toxic dilatation of the colon, and for this, a total proctocolectomy was done. After an extended convalescence, he is now well and healthy.

*Case No. 6* is a forty-six-year old female who had her right colon and terminal ileum removed for ileocolitis. She also had a Meckel's diverticulum. More ileum and colon had to be removed because of obstruction and bleeding and finally, some two years ago, we did a vagotomy and pyloroplasty for very severe duodenal ulcer. Since that time, she has been



Case Number 6

completely well, eats well, and has no diarrhea or discomfort. Should we do vagotomies on more of these patients?

*Case No. 7* is a thirty-nine-year old female who had an ileostomy done ten years ago for severe bleeding. After a year of rather intensive psychiatric treatment, her colon had to be totally removed because of continued severe disease and bleeding. Three years later, she had a baby delivered by Cesarean section and in this instance, the gynecologist felt that she should be sterilized. It is interesting to note that her



Case Number 7



personality was greatly improved by psychotherapy, but the disease persisted.

**In Summary**

We have presented 51 cases of proven ulcerative colitis, which were admitted to one of the two hospitals in Columbus in the last 15 years. The following points were made:

- 1. Ulcerative colitis is relatively rare in Columbus.
- 2. We feel that it may be worthwhile to treat all cases of ulcerative colitis for amebic dysentery at some time during the course of the disease.
- 3. The variety of symptomatology called ulcera-

tive colitis was mentioned and the question was raised as to whether or not the prognosis is effected by the part of the bowel which is diseased.

- 4. The large incidence of associated gastrointestinal lesions with ulcerative colitis was mentioned.
- 5. A rather detailed report of seven surgical cases was given.

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September 8-9, 1966**

Basic instruction in the proper emergency handling and treatment of the injured or acutely ill patient is provided in this course for ambulance attendants, policemen, rescue squad members, firemen, and other interested individuals.



# AREAWIDE HOSPITAL AND HEALTH FACILITY PLANNING

Ralph C. Williams, Sr., M.D., *Atlanta*

- The projected hospital and health facility needs of the Atlanta metropolitan area are discussed.

HOSPITAL and health planning involves the identification of the hospital and health needs with the hospital and health resources appropriate to them. It could be said to be the practice of medicine in relation to populations and facilities in contrast to the practice of clinical medicine which, of course, is in relation to individual patients.

## To Be the Complement

It is the responsibility of the medical planner to be the complement of that of his clinical colleagues by applying different skills toward the common aim of improving the health and health facilities of the community. He will balance the interest of the clinician in the individual by his concern with health workers for the population and facilities as a whole.

The medical planner, therefore, is a health specialist in diagnosis, prevention and treatment of the health problems of the total community.

Recognition of the necessity of voluntary hospital planning in the United States is a significant development of the present decade. Profound social and economic changes, together with notable population shifts in our country have made it important that definite planning be undertaken to adjust to these changes. Careful plans must be prepared to meet the constant progress of industry, recent inventions, scientific progress and new discoveries in the fields of medicine and the prevention of disease.

Local planning for any purpose is of importance. This should include several facets in any urban, suburban or rural area. Planning for a community should include studies of various forms of transportation, expressways, stream pollution, land use, industries, housing, water supplies and the various other factors

that are now a part of the life in the United States in urban, suburban and semi-rural areas.

The over-all objectives of planning for hospital and health facilities are to improve and achieve economy of operation through more effective use of facilities and personnel.

Hospital and health planning for all areas, urban, rural, or anywhere between these, requires adjustment to changes in location and size of population, growth variation in economic conditions and shifts in industrial and agricultural activities. This planning must also take into account constant advances in medical science in the prevention and treatment of disease and disability.

## By Definition

A voluntary hospital and health facility planning agency is any nonprofit organization established on a national, state, area or local level composed of citizens and maintained for the primary purpose of aid-



Program Planning Areas

*Presented at the 112th Annual Session of the Medical Association of Georgia, May 8-10, 1966, Columbus, Georgia.*

ing health leaders and organizations in planning for effective and efficient use of community health facilities. It expends its resources for studies, information and service programs designed to create conditions which enable individual institutions to plan their future development in relation to established community needs.

In providing a mechanism for broader participation and readily available cross-communication, the agency aids coordinated action among multiple institutions and agencies involved in planning for community hospital and health facilities.

The Community Council of the Atlanta Area, Inc., was organized and received its charter in May, 1960. The first Social Planning Council grew out of a Central Council of Social Agencies organized by the Atlanta Chamber of Commerce in 1916.

The purpose of the Community Council of the Atlanta Area, Inc., is, "to cooperate with existing public and private agencies and institutions in the fields of health, education, recreation and welfare, in order to ascertain facts, develop methods, and foster the means whereby the social problems of the Atlanta area may be ameliorated and become less and less a public burden."

The Community Council brings together governmental and nonprofit agencies and organizations around common interests and problems. It promotes coordination and the best use of existing services. It also develops new programs to meet the health, education and welfare needs of the area it serves. It informs the public of these needs and services. The Hospital and Health Planning Department of the Council collects planning data, promotes recruitment and training of health personnel, encourages the best use of health services, and plans for new hospital and health facilities. It is the policy of the Council primarily to serve the five-county metropolitan area, consisting of Clayton, Cobb, DeKalb, Fulton and Gwinnett Counties.

### The Professional Staff

The professional staff consists of three persons, the director (a physician), and two assistant directors, both of whom have a Master's degree in hospital administration. All of the professional staff have backgrounds in hospital management and planning; two of them are experienced in public health work.

Physicians engaged in private practice as well as those in public health work must become aware of the need to insure for their communities the proper distribution and sufficient facilities to achieve and maintain a balance in terms of availability and quality of hospital and health needs for the population to be served. Physicians and medical organizations must increasingly participate in and accept responsibility for assisting in community health facility planning.

The physician of today is the center of a health care team that utilizes a variety of intricate skills. The responsibility of the physician to his patients includes the most appropriate use of services of the health-related professions and facilities in the community. His responsibilities do not end with the provision of medical care, but extend through prescribing and supervising the related services necessary to return the patient to good health.

The physician decides when a patient must be hospitalized, how long he must stay and what diagnostic procedures are necessary and what therapeutic measures must be utilized. The hospital medical staff is also a vital component in planning for hospital and health related facilities.

From the foregoing it is readily apparent that the details of hospital and health planning will vary somewhat from area to area. Therefore, it is necessary that a careful assessment be made of the health needs of the particular area under consideration, and the planning be directed toward the needs of the local area.

There are two or three unmet health needs that are present throughout most of the State of Georgia, though their urgency varies from area to area. These unmet health needs in general are:

1. Shortage of trained professional personnel, especially registered nurses, hospital dietitians, medical technologists.
2. Licensed practical nurses are in short supply in several areas.
3. There is urgent need for additional long term care beds to provide convalescent care and nursing home service in the medium price range so as to be eligible for reimbursement through the various vendor plans.
4. A need for additional general hospital beds also is present in areas where there is a continuing rapid growth of the population.
5. To relieve the pressure for more beds, there is a need for home health care programs so as to permit early discharge of patients and so as to provide home health services to reduce hospital admissions of the sub-acute patients. An organized home health service can be extended to the patient with an "adequate home." Under the direction of a physician, the services of a public health nurse, physical therapist, occupational therapist, social worker, and (home) health aide can be extended to a patient as needed to allow him to be cared for at home by his family. It should be emphasized that an organized home health service is a separate level of patient care, and is not a substitute for acute hospital or nursing home care if



HOSPITAL PLANNING / Williams

such is indicated. In practice, an organized home health service is basically a post-hospital service.

There must be coordinated and continuous efforts on a statewide basis for recruitment for students to enter nursing, medical technology, hospital dietetics, physical therapy and occupational therapy.

The General Assembly of Georgia at the session held in 1966 enacted legislation authorizing students of nursing who have satisfactorily completed two years of professional training to appear for the examination for registration as a nurse.

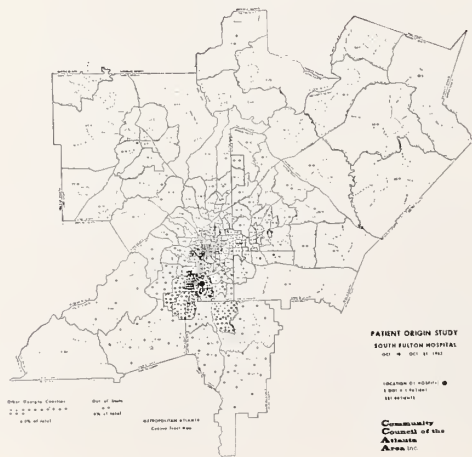
Additional Schools Established

With the construction of several new colleges, both junior and senior, throughout the state, additional schools of nursing should be established in a number of areas. This could be an important factor in increasing the number of available registered nurses within the foreseeable future. Salaries of registered nurses must also be increased to help attract girls into nursing.

As an indication of the necessity of planning on an overall basis the Georgia State Department of Industry and Trade has established Area Planning and Development Commissions in 17 areas in Georgia. An Area Planning and Development Commission is a group of counties and cities which voluntarily join forces to work toward total development of their region. Each member county and city appoints representatives who meet at regularly scheduled intervals to conduct the business of the Commission. A professional staff is employed to carry out a work program approved by the Commission. Operating funds for Area Planning Commission come from Federal, State and local sources.

County medical societies and district public health personnel should be aware of these Area Commissions and maintain close contact with them.

South Fulton Hospital



*South Fulton Hospital, East Point, Georgia, has a bed capacity of 152; average occupancy: 86%.*

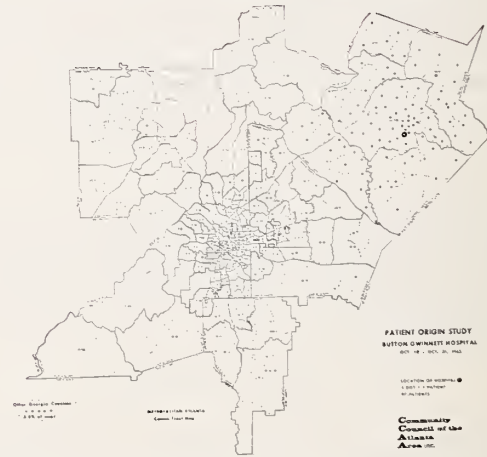
South Fulton Hospital was established in May, 1963, to serve as a general hospital for south Fulton County, and part of Clayton, Fayette and Coweta Counties.

South Fulton Hospital is serving 11% of the patients in the South Atlanta Planning Area, 17% of the patients in the Southwest Planning Area, 29% in the South Fulton Planning Area, and 29% of the patients from Clayton County. Even though South Fulton Hospital will soon be relieved of some of its load from Clayton County, it should, in its own planning, keep a close watch on population trends in the three above mentioned planning areas. Population changes in the Southwest and South Fulton Areas will particularly have a great impact on the demand for services from South Fulton Hospital.

Due to the high occupancy rate of South Fulton Hospital, the new hospital planned for Clayton County should be developed as soon as possible. The establishment of the new Clayton County Hospital and the new convalescent wing planned for South Fulton Hospital should help relieve the over-crowding that exists there now.

A general hospital addition should be added to South Fulton Hospital as soon as the State Health Department can make Hill-Burton funds available.

Button Gwinnett Hospital



*Button Gwinnett Hospital, Lawrenceville, Georgia, had a bed capacity of 35; average occupancy: 43, or over 100%. Additional beds have been added recently, the bed capacity is now 74 and the average occupancy is 65, or 88%.*

Button Gwinnett Hospital is the only Gwinnett County hospital which participated in this patient origin study.

The number of patients reported indicates that the hospital is serving well in its area. Almost 95% of the patients come from Gwinnett County. An additional 5% come from other Georgia counties not in the Atlanta Metropolitan Area.





## HOSPITAL PLANNING / Continued

pital, therefore, is well located geographically for the area it serves.

The problem of the accessibility of the hospital to low-income patients arises not only from the shape of Fulton County and the physical location of the hospital, but also from the patterns of public transportation. The public transportation system centers in the business district, therefore clinic patients and persons seeking hospital admission must either change buses or walk many blocks to reach the hospital. This creates real hardships and delay for the sick, injured, and disabled. The Fulton-DeKalb Hospital Authority may wish to consider this problem and discuss it with the Atlanta Transit Authority, particularly with regard to improvement of the north-south public transportation accessibility.

### A Summary of Activities

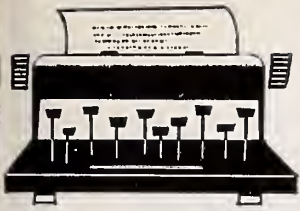
The activities of the Hospital and Health Department of the Community Council of the Atlanta Area, Inc. since its establishment in July, 1965 to date may be summarized as follows:

1. A study of the place of origin of patients admitted to 20 hospitals in the Atlanta Metropolitan Area has been recently completed. This is the first time such a study has been made. The study indicates that 15% of the patients admitted to Atlanta Metropolitan Area hospitals come from other Georgia counties or out of state. Five hospitals, all located in downtown Atlanta, serve 55% of the patients in the metropolitan area.
2. To stimulate Atlanta area hospitals to plan individually for the future, all were recently requested to submit a summary statement of not more than two pages as to their plans for the next ten years. The responses indicate very serious thought is being given to their future plans by almost all of the hospitals. These plans range from the addition of no beds, or services, to the complete rebuilding of the entire plant and increase in bed capacity by 100 beds.
3. A hospital authority was established by a resolution of the Fulton County Commissioners early in April of 1966. This is the Fulton County Hospital Authority, which will plan, construct and operate the Northside Hospital at the intersection of Peachtree-Dunwoody Streets and the Perimeter Expressway. This will be a general hospital of 250 beds.
4. To assist in meeting the demands for service when the Federal Medicare Plan becomes effective in July, 1966, a home health care program is being developed by the Community Coun-

cil. This program will provide several out-of-hospital services through nurses, physical therapists, occupational therapists, home health aides and other qualified personnel. This care will be under the direction of the patient's private physician. This program will cover the five counties of the Atlanta Metropolitan area and about nine outlying counties. This program will ultimately be operated by a board of directors with a professional staff.

5. The Hospital and Health Planning Committee of the Community Council has been enlarged to include representatives from each of the five counties in the Atlanta Metropolitan Area. There are now 12 members of this committee.
6. Contact has been maintained by the staff of the Hospital and Health Planning Department with the Georgia Hospital Association, the Metropolitan Atlanta Council of Hospital Administrators, the Liaison Committee of the Fulton County Medical Society, which includes representatives of the other four county medical societies of the area, the Atlanta Medical Association and various other professional, civic and governmental groups.
7. Studies by the Hospital and Health Planning Department indicate there is need for between 600 and 700 additional general hospital beds in the Atlanta Metropolitan Area. There is also need for at least 2,000 additional nursing home beds. The urgent need for nursing home beds is in the medium priced range so as to be eligible for reimbursement through the various vendor plans. There is no need for additional nursing home beds in the higher priced range. This range is probably over-saturated now.
8. There is need to establish an active recruitment in the Atlanta Metropolitan Area and the entire State of Georgia for students to enter schools of nursing, medical technology, hospital dietetics, occupational therapy, physical therapy, medical records librarianship and other health related fields.
9. At the request of the Georgia Department of Public Health, all requests for funds for construction, renovation or additions to hospitals and nursing homes in the Atlanta Metropolitan Area are reviewed by the Hospital and Health Planning Department and appropriate recommendations are submitted. No project from the Atlanta Metropolitan Area will be considered for Hill-Burton funds until it has been reviewed by the Hospital and Health Planning Department.

*1000 Glenn Building  
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## Our Mandate to Vote

THERE WAS a time, not too long ago, when a half-pint of cheap whiskey would buy a man's vote in many elections. Never a majority of the votes, of course, just some. But this "some" was oftentimes the difference between victory and defeat for the politician who recognized only one creed: victory at any price. What made winning possible on such unscrupulous terms was the fact that many people simply didn't bother to cast their ballot for any candidate.

### Equally Responsible

Since the net effect of those who would sell their vote and those who refused to exercise theirs approaches equality, it would seem possible to build a good case concluding that they were equally responsible for any bad government resulting from their actions.

It is perhaps the most trite, shopworn cliché of our times to say that the basic requirement of citizen-

ship is the exercise of the ballot. Unsophisticated and shopworn as it may be, it is nonetheless a fundamental truth that has passed the test of time. And history is littered with the carcasses of dead governments whose citizens recognized this fact too late.

### To Take Charge

Our stake in the 1966 elections is far greater than most of us imagine. By the most modest, timid appraisal, government has deteriorated almost unbelievably in the past few years and the only sure way to restore it as a servant of the people is for the people themselves to take full charge of the elective process.

If we fail at citizenship's most fundamental obligation then we will surely lose citizenship's most precious inheritance. Either the people, and not machine blocks, shall elect its representatives, or the people will lose the right to do so. It's really that simple.

Vote on November 8.

## The Why and Wherefore of Medical Review Committees

IN THE EARLY DAYS of insurance company payments for medical treatment rendered by a practitioner, the insurance company as a "third party" made their own payment determination from a schedule usually incorporated in the insurance policy. With the recent advent of "major medical" insurance coverage which did not contain a schedule of allowances, insurance companies needed more frequent consultation and guidance from the profession on the economics of services rendered by physicians. On the one hand, the insurance company wanted a medical evaluation of non-routine claims made by physicians—and conversely, the profession itself wanted a voice

in the disposition of these claims. In the interests of better understanding between insurance companies and the medical profession, the concept of medical review committees was established.

### Communication Accomplished

This mutual need for two-way communication between third parties (insurance companies or the Medicare Carrier) and the profession is accomplished through a local medical review committee composed of physicians. In promoting this activity, the Medical Association of Georgia has recommended that its six largest County Medical Societies and eight District



Medical Societies set up their own local medical review committees. For example, if a member of Richmond County Medical Society wished to have a claim reviewed because he believed it to be inequitable, he would submit it to the Richmond County Society Medical Review Committee for evaluation. Physician members of any other County Society in the 10th District would similarly submit their claims to the 10th District Society Medical Review Committee. And in the same manner, if an insurance company or the Medicare Carrier wished medical evaluation of a non-routine claim, they would forward it to the appropriate "large" County Society or District Society Medical Review Committee for recommendation.

The six large County Medical Societies with Medical Review Committees for their memberships are Richmond County (Augusta); Georgia Medical Society (Savannah); Muscogee County (Columbus); Bibb County (Macon); Fulton County (Atlanta); and DeKalb County (Decatur). All other physician members will be covered by their respective District Society Medical Review Committees which are: 1st; 2nd; 3rd; 6th; 7th; 8th; 9th; and 10th.

Either physicians or "insurers" may submit claims to the appropriate Medical Review Committees. However, insurers must fulfill some nine steps prior to their asking Medical Review Committee evaluation of a claim. These steps are set up to make sure that the insurer has made a reasonable effort to adjudicate the claim with the individual physician before requesting assistance from the Medical Review Committee.

### Recommended by MAG

Medical Review Committee structure and procedures in handling claims submitted by physicians or insurers have been recommended by MAG to the County and District Medical Review Committees. A copy of these procedures will be sent to all MAG members in the near future so that the profession may gain a full understanding of how such Medical Review Committees will function in Georgia.

It is also stipulated that either the physician or the insurer may have the right to bring the matter before the MAG State Medical Review Board, but only after the case has been reviewed at the County or District level. A final appeal from a State Medical Review Board recommendation may be made to the Executive Committee of the Council of MAG.

## William V. Wallace of Alabama Joins MAG Staff as Field Representative

**W**ILLIAM V. (DUB) WALLACE, formerly the Executive Secretary of the Medical Association of the State of Alabama, joined the staff of the Medical Association of Georgia September 1, 1966, as Field Representative.

A native of Decatur, Alabama, Mr. Wallace is a graduate of the University of Alabama with a B.A. degree in journalism. An active member of the Church of Christ and a staunch supporter of Alabama Christian College, where he taught a course in journalism last year, Mr. Wallace resided in Montgomery with his wife Sherry and their three daughters.



From November, 1962, until he became Executive Secretary, Mr. Wallace served as Executive Director for the Alabama Academy of General Practice and as Managing Editor of the organization's monthly publication, *The Alabama General Practitioner*.

In addition to his administrative duties, Mr. Wallace served as staff assistant for the Committee on Public Relations and Economics, the Committee on Insurance, the Committee on Administration and Finance, the Committee on Constitution and By-Laws, and the Grievance Committee.

He took a leading role in activities of the Medical Society Executives Association and formerly was Secretary of the Public Relations Council of Alabama.

In his new position, Mr. Wallace will work closely in a liaison capacity between the Medical Association of Georgia Headquarters Office and Georgia county medical societies.

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**Precautions:** Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies. **Side Effects:** Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), onchophylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, cardiovascular and respiratory collapse.



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## THE NEW GEORGIA STATE DRUG VENDOR PROGRAM

Harry L. Williams, M.D.,\* *Atlanta*

**B**EGINNING IN OCTOBER of this year, the Georgia State Department of Family and Children Services will inaugurate a "DRUG VENDOR PROGRAM" whereby drugs will be provided for public assistance recipients. This program is similar to programs which have been in operation as long as 15 years in other states and is in no way related to the Medicare Program. As a matter of fact, Georgia has lagged behind other states in this area and at the present time more than 40 of the states already have drug vendor programs in operation.

### For Purposes of Operation

For purposes of operating the drug vendor program the State Legislature has appropriated \$1,000,000 for the fiscal year 1966-67. This \$1,000,000 will be matched by approximately \$3,430,000 of federal welfare funds to give just about \$4,400,000 annually to pay for prescription drugs for approximately 215,000 public assistance recipients including old age assistance, the blind, the disabled, and dependent children. On the basis of a formula which has been worked out and tested in other states this will amount to \$2.36 per month for each adult in the program and \$.73 per month for each child in the program. Although all public assistance recipients will certainly not require drugs, consideration of the average individual prescription costs in Georgia of approximately \$3.25 would indicate that a single diabetic hypertensive patient could easily need \$15 to \$20 worth of prescription drugs a month. With the previous considerations and the fact that 92,000 of the Georgia public assistance recipients average over 76 years of age, it was obvious from the beginning that the \$4,400,000 available would only be barely adequate for the absolutely essential drug needs of the patient population involved. Because of this and because of unfortunate financial experiences that other states have had in the past, it was decided from the outset that some sort of limitation would have to be placed on the drugs for which the state could pay.

The State Department of Family and Children Services set up a Drug Advisory Committee in April of this year and Mrs. Bruce Schaefer appointed members of the Medical Association of Georgia and the Georgia Pharmaceutical Association plus advisors from schools of medicine and pharmacy in the state to this committee. This committee was charged with the responsibility of helping the State Department of Family and Children Services to come up with a workable plan for the drug vendor program.

The Drug Advisory Committee was in general agreement that some sort of limitation would have to be placed on prescription items for which payment would be made by the state. It was decided that the state would not pay for any of the usual over-the-counter items such as aspirin, laxatives, vitamins or mouth wash. In addition it was recognized early that such items as mild tranquilizers and analgesics which might not be absolutely necessary to the practice of medicine would be potentially too expensive as items for the state program. These foregoing were somewhat arbitrary decisions with which there was general agreement among the members of the state Drug Advisory Committee. It was also soon apparent that the mechanics of validating and paying for prescriptions would be greatly facilitated if the state could furnish some sort of a simplified drug list containing a minimum number of drugs necessary for the practice of good medicine and supply this list to the physicians and pharmacists of the state. In the preparation of the drug list the committee gave consideration to the probable needs of the patient population involved and the proved efficacy of the drugs in question.

### "Generic Prescribing"

Probably the most controversial problem discussed by the Drug Advisory Committee was that of "generic prescribing." Since good quality generic drugs are available in many instances for less than one-tenth the cost of the comparable trade named items, and since generic prescribing would very much simplify the administrative procedures of the state, it was decided by most, but not all, of the advisory

\* Member of the Drug Advisory Committee to the Department of Family and Children Services.

committee members that the state drug list should be constructed on a generic name basis.

The Drug Advisory Committee finally approved a drug list containing 339 items representing different dosage forms for about 160 separate drugs. Of the 339 items 192 are available only as trade name products from a single manufacturer. Forty-nine additional items are supplied solely by two or more major manufacturers and only 98 items are available as generically labeled drugs. Among these last are phenobarbital, ferrous sulfate, diethylstilbesterol and other drugs which are already commonly prescribed by generic names by physicians in practice. The drug list contains a cross index list of generic and trade names and, of course, the physician may prescribe by either generic or trade name any drug on the drug list.

### Supplemented and Revised

There is no question but that the Georgia state drug list for the drug vendor program is a limited one and that many oversights will be found in the list once it is subjected to the test of medical practice. Where drugs essential to the health of patients are not on the list the state will pay for such drugs upon the prior

approval of the prescription by the medical director of the drug vendor program. In addition it is expected that the initial drug list will have to be supplemented or revised at frequent intervals especially during the first few years of the program.

We would hope that this cooperative effort between the physicians and pharmacists of the state and the State Department of Family and Children Services will be a successful one and that it will bring to a large indigent and underprivileged group of Georgia citizens more of the benefits of modern medicine than they have been able to afford in the past.

The Drug Advisory Committee would like to apologize in advance for oversights in the drug list either of necessary drug items or of listed trade name equivalents and to state that for the most part these will have been simple errors of omission that will be corrected by future lists. In urging cooperation among all involved in this new program, the Drug Advisory Committee would like to reiterate that the funds available are severely limited in terms of the patient population and that any restrictions imposed by the program are only the result of an attempt to make the program financially possible.

*Emory University School of Medicine*

## 1966 CALENDAR OF MEETINGS

### State

October 20-22—Symposium on "Industrial Medicine: The Doctor's Role in Occupational Health," sponsored by the Mound Park Hospital Foundation, St. Petersburg, Fla.

October 27-29—Postgraduate course—Seminar on Neurology-Neurosurgery sponsored by the College of Medicine, University of Florida, Gainesville, Fla.

November 10-12—Pediatric Seminar, "Metabolic and Nutritional Disorders in Children," sponsored by the College of Medicine, University of Florida, Gainesville, Fla.

November 17-18—Obstetrics and Gynecology Seminar sponsored by the College of Medicine, University of Florida, Gainesville, Fla.

November 28-December 1—Third Annual Postgraduate Course on Pulmonary Function in Health and Disease, sponsored by the American Thoracic Society, the Louisiana Thoracic Society, the Tulane University School of Medicine, the Louisiana State University School of Medicine, and the Alton Ochsner Medical Foundation; Auditorium, Tulane University School of Medicine, New Orleans, La.

December 8-9—"Pediatrics," sponsored by the Medical College of Georgia, Dept. of Continuing Education, Augusta.

January 27, 1967—Vincristine Symposium, "Current concepts of biological, pharmacological and biochemical action, and comprehensive summaries of therapeutic results obtained in treating solid tumors and the leukemias," sponsored by the Pediatric Division of the Southwest Cancer Chemotherapy Study Group, St. Jude Children's Hospital, Memphis, Tenn.

April 30-May 1-2, 1967—113th Annual Session of the Medical Association of Georgia, Marriott Motor Hotel, Atlanta.

### National

November 27-30—American Medical Association (Clinical Convention), Las Vegas, Nev.

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\*Multiple of adult Minimum Daily Requirement supplied.

†The need for these substances in human nutrition has not been established.

*Indications:* 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

*Dosage:* Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

*Contraindications:* As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

*Side effects:* Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

**Merrell**

THE WM. S. MERRELL COMPANY  
Division of Richardson-Merrell Inc.  
Cincinnati, Ohio 45215





## THE ORGANIZATION OF STATE MEDICAL ASSOCIATION PRESIDENTS

THIS IS A new activity on the scene of organized medicine in America. The group is now three years old, originally conceived and activated by Dr. Theodore Raiford of Asheville, North Carolina. It is with distress and sorrow that we heard of his death on the way home from the meeting in Chicago on August 26 and 27. He had at that meeting been voted a permanent member of our group. Organized medicine has lost an active and staunch supporter.

### The Format

Membership is confined to Presidents; Presidents-Elect and Immediate Past Presidents. Officers shall be composed of an advisory committee of six members who shall elect one member as chairman. The meetings are on an informal basis, with free discussion of current problems of mutual interest in our respective states and on a national level. Prominent speakers are invited for presentation and discussion of subjects germane to their areas of activity and which are of interest to us all.

At the recent meeting (Aug. 26-27) there were 37 presidents and 33 past presidents and presidents-elect present representing all areas of our country.

Mr. Joseph Stetler, President of the Pharmaceutical Manufacturers Association, discussed state journal advertising and the matter of exhibits at state meetings. Some companies feel present methods are becoming obsolete and are on the way out. Some feel journal advertising is passé and exhibits not well attended. However, in the past year, state journal advertising has increased 50% nationally and over 100% in the South. The increase is more than in commercial and "give away" journals.

### Survey Made

Our Mr. Milton Krueger has made a survey of the matter: 46 states use exhibits, 18 finance solely by exhibits, seven others partially by exhibits and partly

by contributions. One state accepts contributions in lieu of exhibits (\$600). Each year sale of exhibits poses more of a problem, particularly when meeting in smaller towns with less attendance.

Mr. Stetler stated that some companies now exhibit only because others do, or for fear of falling into disfavor with doctors. Also, there have been implied threats of boycott for not advertising in state journals.

### A Possible Solution

One suggestion from Mr. Stetler was a commercially sponsored scientific program at annual sessions. Companies would submit programs to be judged by state associations, the winner to give the programs and pay for the expense. Other companies could also have exhibits.

Another suggestion: the Pharmaceutical Manufacturers Association could have joint meetings with state associations to discuss all facets of the problem and maybe come up with other plans and methods.

It was also suggested that a conference concerning generic prescription problems be held. A motion was made and passed that such a conference be set up by the American Medical Association.

Dr. Philip Lee, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education and Welfare, also addressed our meeting. He reviewed a brochure of 32 pages previously distributed to us, entitled, "Health Legislation in the Nineteen Sixties—Where Do We Go From Here?" This covered every conceivable category and what federal plans are for approaching problems.

Under Medicare alone we expect more than nine million hospital bills and 30 million doctors' bills to be paid yearly.

In summary he outlined *These Goals of the President*:

1. Modern medical care for every person of every age whatever his means.
2. A life expectancy of 75 years—five more years than at present for every child born in America.
3. Achievement for every child born in America no matter what his color, the lowest mortality rate in the world.
4. Elimination of smallpox, measles, diphtheria and whooping cough.
5. Elimination of heart damage caused by rheumatic fever.
6. Elimination of tuberculosis as a threat to health, happiness and economy in America.
7. Reduction of death rate from heart disease, cancer and stroke by at least 300,000 each year.

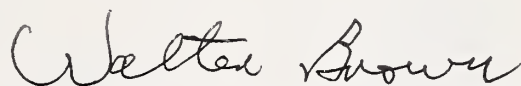
### We Cannot Settle for Less

The President has said "We cannot settle for less." Dr. Lee adds "You and I and our professional colleagues as physicians cannot settle for less. We owe

this to our patients, to our fellow Americans. We owe this to our medical traditions. We owe this to ourselves."

This speaks all too plainly as to the aims of government to completely control the methods and concepts of medical practice in our country. It behooves us to continue to resist with all our means and efforts this total encroachment upon, and regulation of, our profession.

We should continue to support financially and by active participation those men running for or already in public office who are in sympathy with our aims and ideals. I urge all our members to give extra time and effort to the accomplishment of these purposes.



Walter E. Brown, M.D.

President, Medical Association of Georgia

## "MEDIC ALERT" SAVES LIVES

Ten years ago, a California physician whose daughter almost died as a result of a tetanus antitoxin-triggered anaphylactic shock, founded the Medic Alert Foundation International. Today, more than 160,000 people wear the nonprofit Foundation's increasingly familiar stainless steel emblems on the wrist or around the neck, each calling immediate attention to one or more of 200 hidden medical problems. When necessary, a collect telephone call to the Foundation's Turlock, California, headquarters, physicians and other authorized personnel may obtain additional medical information that may save the life of a conscious or unconscious person wearing a Medic Alert emblem. The telephone number 209-634-4917 appears on all emblems.

### Emblazoned in Enamel

Each emblem carries the words "Medic Alert" and the staff of Aesculapius emblazoned in red enamel. The reverse side of the emblem contains one or more key words, the Foundation's telephone number and the wearer's identifying number corresponding to an information card in the Medic Alert files. Thus in an emergency, physicians or others at any hour of the day or night, can call the Foundation's Central Answering File and obtain further medical facts plus the wearer's name and address, his next of kin and the name of his family or personal physician.

The American Medical Association estimates that 40 million Americans—one in five—should be wearing a medical signaling device.

The one-time cost of a Medic Alert emblem and a round-the-clock information service is \$5.00 (sterling silver emblems are \$7.50). However, the Foundation provides memberships without cost for persons whose physicians state they are unable to pay.

The Foundation has a dual purpose: (1) to educate people who need to obtain and wear an emblem, and

(2) to teach physicians and qualified first aid personnel to look for the emblem. At present 30 national and overseas airlines instruct their hostesses to look for Medic Alert emblems, and many industries provide information about Medic Alert in their industrial health programs.

A few of the key words or phrases often used are:

Allergic to Penicillin	Epilepsy
Taking Anticoagulants	Diabetes
Wearing Contact Lenses	Glaucoma
Hemophiliac	Allergic to Codeine
Taking Digitalis	

Some emblem wearers are laryngectomees, others have a collapsed lung or Meniere's disease or some other problem. The youngest emblem wearer is one year old, the oldest is 92.

The Medic Alert Foundation International has affiliate organizations in Canada, the United Kingdom and the Republic of Ireland, the Netherlands, Belgium, Spain, South Africa, New Zealand, the Philippines, and is registered in 24 other countries. It is officially endorsed by the American Academy of General Practice, the Student American Medical Association, the American Association of Nursing Homes, the American Legion, the International Association of Chiefs of Police, the National Sheriffs' Association, National Association of Life Underwriters, the Association of Life Insurance Medical Directors and many state and county medical societies. It also has the endorsement of the President's Committee on Employment of the Handicapped.

Policies in this nonprofit foundation are established by a Board of Directors assisted by a Medical Advisory Committee. Further information of interest to physicians and their patients and application forms may be obtained by writing to *Chester L. Watts, Executive Director of the Medic Alert Foundation, Turlock, California 95380.*



# New low-cost tetracycline/antifungal therapy

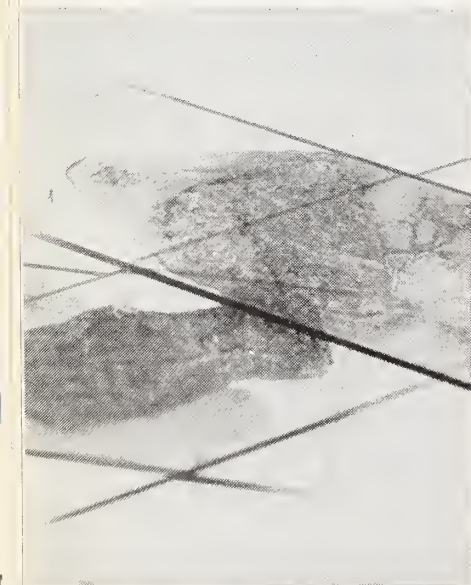
for broad-spectrum activity  
plus specific antifungal prophylaxis  
at significant patient savings

Whenever tetracycline is indicated in these candidates for Candida:

1. diabetic patients
2. nonpregnant women with a history of recent or recurrent monilial vaginitis
3. elderly or debilitated patients



4. patients with a past history of moniliasis
5. patients on long-term tetracycline or corticosteroid therapy



**BRISTOL THERAPEUTIC SUMMARY:** For complete information consult Official Package Circular. **Indications:** Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. **Contraindications:** The drug is contraindicated in patients hypersensitive to its components. **Warnings:** Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). **Precautions:** Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. **Adverse Reactions:** Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. **Usual Adult Dosage:** 1 capsule *q.i.d.* Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals. **Supply:** Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

**BRISTOL**

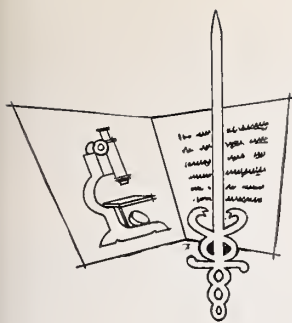
BRISTOL LABORATORIES  
Division of Bristol-Myers Company  
Syracuse, New York

## Tetrex-F®

Each capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units.

Tetrex-F is priced lower  
than most  
tetracycline-antifungal products.





## CANCER IN CHILDREN—WILMS'S TUMOR

Howard M. Sigal, M.D., *Smyrna*

CHILDHOOD CANCER, although fortunately rare, remains the leading cause of death among the diseases of school age children. Because of its often insidious onset and frequent tendency to masquerade as a trivial disorder in early stages, malignant disease constitutes a challenge to the alert pediatrician.

Except for leukemia, neuroblastoma remains the most common form of cancer in the pediatric age group.

### MORTALITY FOR THE FIVE LEADING CANCER SITES UNDER AGE 15, 1963

Leukemia .....	2,175
Brain .....	992
Reticulo- and Lymphosarcomas .....	327
Kidney .....	204
Bone .....	171
<hr/>	
Total .....	3,869

Although cancer accounts for approximately 18% of the deaths from disease in children one to 14 years of age, the experience of any physician with neoplasms in early life is likely to be limited, and their importance is often not appreciated.

There are certain sites of predilection, however, which differ sharply from the common locations of cancer in adults. The central nervous system, eye, renal and adrenal areas, hematopoietic system, soft tissues and bone are the most common sites in the pediatric age group. Sarcomas are far more common in children than are carcinomas. In adults, the reverse is true.

According to Arey, every abdominal solid mass in an infant or child should be regarded as a malignant neoplasm until its exact nature is determined by histologic examination of the removed tumor. Needless palpation of the mass should be strictly forbidden, and complete removal should be effected as soon as adequate clinical evaluation and preparation for operation can be made. This period usually need not exceed 24 to 48 hours. Treatment other than by surgical excision should *not* be instituted until an unequivocal diagnosis has been established by histologic study. Observance of these principles should

prevent a number of needless deaths *from cancer in infants and children.*

Wilms's Tumor (Embryoma of the kidney) is one of the most common abdominal neoplasms of early life, the majority occurring in the first four years. Usually unilateral, Wilms's Tumor can occasionally arise independently of the kidney.

The pediatrician in busy practice will undoubtedly find himself in the unfortunate circumstance of diagnosing Wilms's Tumor. Presenting as an abdominal mass, usually firm and non-tender, it may extend as low as the iliac fossa. Since Wilms's Tumor does not extend beyond the midline, it may be differentiated from another common intra-abdominal neoplasm of childhood, neuroblastoma.

Intravenous pyelography rarely adds much to diagnosis of Wilms's Tumor except to demonstrate distortion of the renal pelvis. Displacement of the kidney is more likely an indication of neuroblastoma. Since no pathognomonic signs exist, histological examination is the only means of establishing a diagnosis.

When a persistent abdominal mass which *could* be a retroperitoneal neoplasm is present, immediate surgical exploration is indicated (within 24 to 48 hours). The mass must not be palpated excessively by over-zealous house officers, and when pyelography demonstrates an adequately functioning opposite kidney, surgery should be performed promptly. Preoperative chest x-ray may reveal signs of pulmonary metastasis.

Occasional cures of Wilms's Tumor by irradiation alone have been reported, but preoperative irradiation is contraindicated since occasional benign lesions and normal tissue may be injured. Postoperative irradiation to the site remains debatable, although it is currently routine despite the possible damage to the opposite kidney.

Survival rates vary, but 20% survival in two years and 5% survival in ten years is generally accepted. Recent statistics may indicate an improved and hopeful outlook for the future as survival rates are steadily increasing.

*Cherokee Medical Building*

Approved by the Professional Education Committee, Georgia Division, ACS.



## NEW VA HOSPITAL AT ATLANTA OFFERS ULTIMATE IN FACILITIES FOR BETTER PATIENT CARE



The new \$15 million, 12-story, 572-bed Atlanta VA hospital is situated on a 26-acre track of the old Walter T. Candler "Lull-water Farms" overlooking the famed Candler Lake on Clairmont Road. It is adjacent to the Emory University Medical School, with which it is affiliated in a teaching and residency training program.

After a little over two months' operation, all systems of the revolutionary new \$15 million, 572-bed Atlanta Veterans Administration hospital are indicating that this new concept could well be in the future for all new VA hospitals.

### "Friesen Concept"

Embodied in the design of this high-rise, 12-story new hospital is the "Friesen Concept," designed as an attempt to cope with increased costs of hospital care, hospital utilization, and the increasing numbers of personnel needed to care for the veteran-patients.

This concept was designed by Gordon A. Friesen Associates, Washington, D.C., for the VA to help it build plants that will be years ahead of modernization steps necessary to keep pace with the giant strides of modern medicine.

The design provides the proper tools to work with, when and where they are needed, so that professional and allied skills are not diluted with functions and duties that could be performed less frequently and by less skilled personnel, thus contributing to more direct patient care.

The nine-story nursing area is a high-rise tower on top of the large three-level base which houses all service facilities for the hospital. Thus all the service facilities such as x-ray, laboratory, surgery and central supply, because of their dynamic role in medical care programs, are capable of being expanded on a horizontal plane.

### "New" Central Supply

The core of this concept is the "Supply Processing and Distribution" center, which is the heart of the production line flow of supplies and materials to all departments in the hospital. This complex, referred to as the "processed stores," is the control point from which all clean supplies and materials are moved to the areas of need and also the control point to which all soiled supplies and materials are sent.

It includes the receiving area, a bulk storage area, central sterilization including a special decontamination room, processed stores, soiled receiving areas, a laundry and a pharmacy, as well as all other delivery functions which are centralized at this one control point.

### Conveyor System

Distribution to each patient floor is accomplished largely by vertical conveyor, which carries supplies to the clean supply core on each floor. Used and soiled articles are returned by a separate down conveyor and by trash chutes in the "dirty" side of the supply core.

Patients' rooms are single, two-bed and four-bed rooms located around the perimeter of the central area. Each is a self-contained unit with everything present for the proper care of the patient except those services peculiar to a special department or service such as surgery, EEG, x-ray therapy, etc.

Each room has a service alcove containing a lavatory and a commode, and some have showers and a closet for each patient's personal possessions and clothing.

### "Nurseservers"

Also in the service alcoves, built into the corridor walls, are unique "Nurseservers," or storage cabinets, with double doors opening into the service alcoves and double doors opening onto the corridor. All supplies needed for in-patient care for a 24-hour period are contained in the clean side of the Nurseserver. Soiled items are placed in the soiled side of the partitioned cabinet, which is vented into an exhaust channel.

### Processed Stores

Making certain that these Nurseservers contain the proper supplies for the individual patient's needs is one of the main missions of the "processed stores." A clean supply room is situated on each floor above the processed stores where "complement carts" containing estimated needs for a 24-hour period are supplied from the vertical conveyor and kept available for the using units. These carts are exchanged once every day during the night shift when corridor and elevator traffic is light.

During the day shift, a ward technician from the processed stores is on duty in the clean supply room. The technician stocks the clean side of the Nurseservers and removes soiled supplies from the corridor side on a regular schedule determined by the situation on the individual ward. The technician may be contacted by intercom from any patient room if supplies not in the Nurseserver are needed by the doctor or nurse.

When the technician leaves the clean room, he switches the intercom to route any call to the processed stores, where a dispatcher—on duty at all hours, fills the need immediately on the vertical conveyor.

Other time-saving features for the professional personnel include: Central medical gas systems at each bed, providing oxygen, nitrous oxide, suction and air; and vocal-visual call systems at each bed connected to a receiving and sending console in the nurse station for instant patient-nurse communication.



Also available is a physiological monitoring system for seriously ill patients offering the nurse continuing check on the patient's systolic and diastolic blood pressures, pulse and heart rate, body temperature, respiration rate, electrocardiogram and electroencephalogram.

### Data on Discs

From any phone in the treatment areas, surgical suites, and even the morgue, the doctor can pick up a phone day or night and by dialing a certain number be connected to a central dictating console and get all data recorded on discs for transcription on the spot without having to rely on copious notes and/or a long memory.

From any one of 59 sending and receiving stations at strategic points throughout the hospital a "30-second messenger service" to another point in the hospital is available by electronically-routed pneumatic tube carriers for transmitting communications, drugs or laboratory specimens.

Now available to veteran-patients in the new hospital is a Cobalt-60 teletherapy unit for treatment of cancer.

In addition to the vertical conveyors for clean and soiled supply, two other vertical conveyors will convey

the food trays to the tower section, and one down for dirty food trays. There is no patient dining room, all meals are served in the patient rooms or in the day rooms for each ward.

From a housekeeping standpoint, another time-saving innovation is aluminum, double-paned windows with the venetian blinds sealed between the panes of glass so they will never get dirty. Furthermore, the windows are pivoted in the middle to permit reversing for cleaning both sides from the inside.

The out-patient clinic has been moved from the downtown office to the new hospital, after 20 years, to afford more specialized facilities and treatment for the VA patients.

### Vital Affiliation

Adjacent to the Emory University School of Medicine, with which it has been affiliated in a teaching and residency training program since 1946, the new VA hospital will be able to give more specialty training to the school's graduate doctors, and it will have immediately available advice and assistance on a consultant and attending basis of more of the noted doctors on the school's staff.

## AMA PUBLIC RELATIONS INSTITUTE HELD AT CHICAGO

The public relations problems which face the medical profession on a day-to-day basis and how to deal with them—this was the theme of the AMA Institute on Public Relations held August 24-25, 1966, in Chicago at the Drake Hotel.

### On the Part of the Individual Doctor

The primary emphasis brought by the keynoters of the Institute dealt with the absolute importance of public relations on the part of the individual doctor. Dr. Otis D. Wolfe of Marshalltown, Iowa, stressed the image of medicine to the public as generated by the intimate person-to-person contact in the M.D.-patient relationship. The important part played by the physician's office personnel was also emphasized.

Dr. Robert Q. Marston, Associate Director of the National Institute of Health and Chief of the Division of Regional Medical Programs, presented the latest information on current concepts in implementing the "Heart Disease, Cancer and Stroke" program. No part of this program is to be concerned with construction, but it is rather being developed as a program to implement communication on up-to-date treatment and diagnostic methods to all community levels of medical practice.

### Medical Care as a "Right?"

A question and answer period on Friday morning was fielded by an excellent panel of AMA executives. A significant portion of this period centered around a discussion of the developing trend of the American public to consider medical and health care as a "right." Several commentators showed that this tendency has been created by the rapidly burgeoning quality of health care available now as compared with even the relatively recent past.

The Institute was culminated by, "Freedom—The Wave of the Future," delivered by Dr. Charles Hudson,

AMA President, followed by an AMA Headquarters tour.

Several features of this program will be incorporated in the Annual County Society Officers Conference which will be held this year at the Riviera Motel in Atlanta on Saturday and Sunday, February 4-5, 1967.

## AMA and MAG TO CO-SPONSOR TWO CLINICAL LECTURES IN GEORGIA

The Medical Association of Georgia, in cooperation with the AMA, is co-sponsoring clinical lectures in two schools during the 1966-67 academic year. The AMA Council on Foods and Nutrition initiated the clinical nutrition lecture program in the fall of 1964. The program is being carried out on a regional basis with several lecturers participating.

The lectures are designed to stimulate undergraduate students to consider careers in the health sciences, as well as to inform the audience of recent developments in the field of nutrition.

A total of 36 lectures this year have been scheduled in the eight-state area which includes Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, South Carolina and Texas. Two of the lectures are scheduled in Georgia.

R. H. Kampmeier, M.D., Professor of Medicine Emeritus, Vanderbilt University School of Medicine will give the following lectures:

1. University of Georgia in Athens  
Tuesday, October 18  
No specific time has yet been determined.
2. Georgia Southern College in Statesboro  
The lecture will be scheduled on either Monday, February 6 or Tuesday, February 7.  
A specific time has not yet been determined.





## PATENT DUCTUS ARTERIOSUS

Roy H. Crispin, M.D., *Atlanta*

THE PATIENT who is first seen with a diagnosis of patent ductus arteriosus is very often a healthy appearing infant whose parents have been told that their child has a heart murmur caused by a birth defect which needs surgical correction. Many times it is difficult for parents to realize that such a normal appearing child needs surgery. It then becomes the responsibility of the attending physician to explain how a defect such as this, which appears to be an innocuous one, does not mean that it is compatible with a long life and little or no disability. The life expectancy of a patient with a patent ductus arteriosus who does not have it operated upon is approximately 35 years. The reason for early surgery, when no contraindications exist, is therefore apparent. The ductus is a channel which joins the pulmonary artery (or its left branch) with the aorta, thereby establishing a by-pass through which a shunt of blood occurs.

### Symptoms Vary

The symptoms of a patient with this defect vary from none to full blown cardiac failure. The latter occurs mainly in those cases where pulmonary hypertension exists.

The heart is usually not enlarged, and systolic blood pressure is normal while diastolic is slightly decreased. A continuous "machinery" type murmur is heard in the second left intercostal space, often accompanied by a thrill. The murmur is present throughout systole and extends through the second heart sound into diastole.

If the shunt is small, the chest x-ray is normal. In

larger shunts, it may reveal left ventricular and left atrial enlargement with a prominent pulmonary artery, increased vascular markings and pulmonary artery pulsations.

Patients fall into one of three categories:

- If pulmonary hypertension has occurred and reverse flow exists, the patient will not tolerate interruption of his ductus.
- If the shunt is nearly balanced, the operation is probably indicated but it involves a greater risk.
- If the shunt is from left to right, the risk is low (operative mortality less than 1%), the results are good and the operation is indicated. Waiting in these cases is an error because in time the shunt will reverse and the patient's future is in jeopardy.

It is generally accepted that all patients aged two or over who fit the above ("c") criteria are candidates for surgery. Nevertheless, each case should be individualized and earlier surgery is sometimes necessary to eliminate the shunt in a critically ill infant.

Subacute Bacterial Endocarditis is always a possible complication of congenital heart disease, and a patent ductus is no exception. This requires the judicious use of antibiotics followed by elective surgery when blood cultures become sterile. It is pertinent to remember that sometimes the organisms are resistant to antibiotics, and cases have been reported where surgical division of the ductus in this situation has been curative.

*340 Boulevard, N.E.*

*Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.*

## PART OF HEART DRUG STUDY CONDUCTED AT GRADY HOSPITAL

Part of a nationwide study to determine which of five drugs is best in treating patients who have suffered at least one heart attack is underway at Grady Memorial Hospital.

The Department of Medicine, Emory University School of Medicine, received a grant of \$71,074 from the National Institutes of Health for the initial year of a planned seven-year coronary drug project. The initial grant covers the year beginning June 1, 1966.

Dr. J. Willis Hurst is chairman of the department, and Dr. Robert C. Schlant, associate professor of internal

medicine, Emory University School of Medicine, is director of the project. It will be conducted with in-patient and out-patient volunteers at Grady Memorial Hospital, where the school conducts the major portion of its clinical teaching program.

The study at Grady is part of a nationwide undertaking which is eventually expected to embrace approximately 50 institutions and about 7-8,000 patients. Patients in the study will be observed five years. Dr. Schlant said that by the end of the first two years he hopes to have 200 Grady patients in the study.



### VOLUNTARY STERILIZATION LAW EXPLANATION OF REQUIRED FORMS

John L. Moore, Jr. and Trammell E. Vickery, *Atlanta*

**T**HE 1966 GENERAL ASSEMBLY of Georgia passed, and the Governor of Georgia subsequently signed into law, an Act which specifically authorizes operations intended to produce sterilization where the particular facts involved in a case permit reliance on the Act and if the procedures set out in the Act are followed.

#### Requirements Outlined

The requirements of the 1966 Act have been outlined and explained by counsel for the Medical Association of Georgia and counsel for the Georgia Hospital Association to their respective clients. The generality of the statutes requirement may be summarized as follows:

1. The patient must be a legally married, competent adult.
2. A request in writing must be made by the patient and by his or her spouse to the physician asking for the performance of the sterilization procedure.
3. A full and reasonable medical explanation must be given by the surgeon who performs the operation to the patient and to the patient's spouse.
4. There must be a written consultation agreement signed by one other physician or surgeon licensed to practice medicine and surgery pursuant to the provisions of Chapter 84-9 of the Georgia Code, which consultation agreement must recommend that the performance of the sterilization procedure on the named patient is in the best interest of that patient and his or her spouse.
5. The consultation agreement, the written request of the patient and the consent of the patient's spouse must all be attested to before a notary public.

It will be noted that this Act does not purport to deal with all operations intended to produce sterilization.<sup>1</sup>

The Act does provide that when any operation is performed in compliance with the provisions of the law, civil and criminal liability is avoided. The desirability, if not the legal necessity, of tracking this statute where possible is apparent in view of the act's specific authorization. No statute exists specifying guidelines and procedures with respect to performance of therapeutic sterilizations.

#### Oral Request Occurs

An oral request from a patient for an operation producing sterilization will frequently occur in a physician's office. Under the statute an oral request cannot be relied upon but can give rise to an initial judgment by a physician as to whether he would or would not be willing to perform the requested operation. If, after discussion with the patient either at his office or in the hospital, the physician decides that a sterilization operation is advisable, it is then necessary for the physician to discuss fully the operation with the patient and the patient's spouse. The suggested form evidencing the written request of the patient and the patient's spouse should be signed by both the patient and the patient's spouse in the presence of a notary public and then notarized only after the physician has made full explanation to the parties.<sup>2</sup>

It is also desirable for the physician to sign the written request to evidence his active participation in making the necessary explanations and in obtaining the appropriate execution of the form. It should be kept in mind that responsibility for making the necessary explanations is that of the physician. Operations producing sterilization on the basis of consent are clearly not regarded by this law as routine and obtaining the necessary documents should be handled accordingly.

1. The Act, as passed, specifically provides that the procedures set forth in said Act are not required to be complied with where for sound therapeutic reasons medical or surgical treatment by a Doctor of Medicine may incidentally, as a part of such treatment, involve the nullification or destruction of the reproductive functions. It is nevertheless recommended that the outlined procedure and forms explained herein be utilized for even therapeutic sterilizations where possible.

2. Counsel for the Medical Association of Georgia has suggested that a physician have a written explanation for suggested documentation of what explanation was made. Attention is invited to the article on Voluntary Sterilization by John L. Moore, Jr. appearing on the Legal Page of the April, 1966 issue of the Journal of the Medical Association of Georgia.



The written request should be executed by the patient and the patient's spouse in duplicate. This will permit retention of one fully executed copy by the physician. The other executed copy should be attached to the patient's hospital chart in cases where the operative procedure is performed in the hospital. It is the personal responsibility of the physician to see to it that said written request becomes a part of the patient's chart and this should be done prior to the operation. In addition, the hospital should still require the execution by the patient of its usual operative permit in accordance with procedures customarily prevailing in most hospitals.

An Additional Requirement

The Written Consultation Agreement, also notarized, is an additional requirement of the statute. The consultation required by the statute should be had either in the office of the physician who has requested the consultation or at the hospital preceding the surgery, but it is important to note that the consulting physician should, in addition to the attending physician, make a full explanation of the nature of the operation to both the patient and the patient's spouse and fully satisfy himself that the parties have made a written and properly notarized request for the operation and understand fully what they are doing. The

consulting physician should then make an independent judgment, which independent judgment is in agreement that the operation for sterilization is in order and may proceed as requested. It will be noted that the suggested form contemplates that the attending physician and consulting physician will jointly see the patient and the patient's spouse. Although the judgment reached by each of the physicians should concur as to the ultimate result and the decision reached should be based upon the independent evaluation of each physician.

This Written Consultation Agreement should also be executed in duplicate and notarized. One executed copy should be made a part of the patient's chart just as was the written request for the procedure.

Properly executed copies of the written request and consultation agreement and execution of the hospital's customary operative consent should, all taken together, establish the necessary criteria for bringing both hospital and physician under the protective umbrella of the statute.

It is believed that the suggested forms are adequate for the protection of the interests of both the physician and hospital. Counsel for the Medical Association of Georgia and the Georgia Hospital Association have cooperated in preparing the forms and this advice with a view toward eliminating the necessity for multiple forms.

Forms

Date . . . . . Time . . . . . A.M.  
P.M.

We, the undersigned husband and wife, each being more than twenty-one years of age and of sound mind, being and representing hereby that we are lawfully married, request Dr. . . . . , and assistants of his choice, to perform upon . . . . . the following operation: . . . . .  
(Name of patient)

. . . . .  
(State nature of operation)

It has been explained to us, and we understand, that this operation is intended to result in sterility although this result has not been guaranteed. We understand that a sterile person is NOT capable of becoming a parent.

We, and each of us, have been informed by our physician of the nature of the operation to be performed, risks involved, and the possibility of complications. We, and each of us, desire the performance of such operation, assume risks and consequences involved and authorize the performance of said operation at . . . . . Hospital, or at . . . . .  
(State where operation is to be performed if other than a hospital)

We voluntarily request the operation and understand that if it proves successful the results will be permanent and it will thereafter be physically impossible for the patient to inseminate, or to conceive, or bear children.

This statement, which has been executed in duplicate, is intended to be the statement required of the patient and spouse under Section 2 of Act No. 534, Ga. L. 1966, p. 453.

Signed . . . . .  
(Husband)  
Signed . . . . .  
(Wife)

. . . . .  
(Physician's signature)

Continued →

Personally appeared before the undersigned Notary Public ..... (husband) and ..... (wife), personally known to me, who signed the foregoing consent in my presence after having read the entire statement to me and indicated that they understood it; and further that each of them signed freely and voluntarily without coercion of any kind by any person.

.....  
Notary Public

My Commission expires:  
.....

CONSULTATION AGREEMENT

Date ..... Time ..... A.M.  
..... P.M.

We, the undersigned Medical Doctors, each being a Doctor of Medicine duly licensed to practice medicine and surgery in the State of Georgia pursuant to Chapter 84-9 of the Code of Georgia of 1933, as amended, hereby agree, represent and state that:

1. Each of us separately and both of us, acting in collaboration or consultation, have examined ..... and have made a medical evaluation of ..... and have agreed and advised said patient and said patient's spouse of our agreement that said patient should be sterilized by the performance of the following operation: .....  
.....  
.....  
(State nature of operation)

2. We, and each of us, have explained to the said patient and the said patient's spouse that the above stated operation, which has been requested and consented to by both parties, in writing, is intended to result in sterility although this result has not been guaranteed. We, and each of us, believe that the said patient and the said patient's spouse understand that a sterile person is not capable of becoming a parent.

3. The said patient and the said patient's spouse have voluntarily requested the above described operation in writing and each of us believes that the said patient and the said patient's spouse understand the nature of the operation, risks involved, and possibility of complications and that if the operation proves successful the results will be permanent and it will thereafter be physically impossible for the patient to inseminate or to conceive or to bear children.

4. Each of the undersigned believes and has been informed by both the said patient and the said patient's spouse that they have voluntarily requested the performance of the above described procedure on the patient and that their request is not the result of any force or coercion by any person.

Signed .....  
Medical Doctor  
Signed .....  
Medical Doctor

Before the undersigned Notary Public personally appeared ..... (Medical Doctor) and ..... (Medical Doctor) who, first being sworn, stated that the statements of the foregoing Consultation Agreement are true and then executed the same in my presence, the date and time above written.

.....  
Notary Public

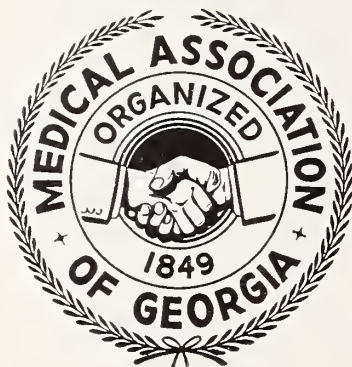
My Commission expires:  
.....

Prepared at the request of The Medical Association of Georgia and the Georgia Hospital Association. Mr. Moore is a member of the firm of Alston, Miller & Guines, General Counsel to The Medical Association of Georgia. Mr. Vickery is a member of the firm of Jones, Bird & Howell, General Counsel to the Georgia Hospital Association.



# 1967 Annual Session

April 30-May 1-2, 1967 – Atlanta, Georgia



## Second Call for Scientific Papers

All titles must be submitted to the  
respective program chairmen listed  
below before November 1, 1966

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when congestion is complicated by sulfa-susceptible  
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**WARNING:** Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. **PRECAUTIONS:** Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. **ADVERSE REACTIONS:** As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If

one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. **PACKAGE INFORMATION:** Trisulfaminic Tablets: Supplied in bottles of 100 tablets. **CAUTION:** Federal law prohibits dispensing without prescription.

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## Breast-feeding and the “modern mother”

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

### The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

### The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

### A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: *Obstet. & Gynec.* 27:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

### Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

### Contraindications:

Established or suspected mammary cancer or genital malignancy.

### Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

### Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

## Deladumone® OB

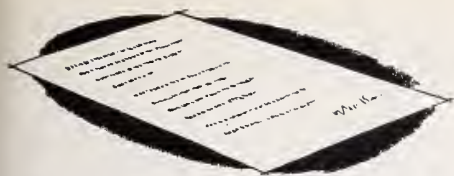
Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

**Single-dose injection for lactation inhibition**



*'The Priceless Ingredient' of every product is the honor and integrity of its maker.*





## ABSTRACTS BY GEORGIA AUTHORS

**Whitesides, Thomas, Jr., M.D., and Kelly, Robert P., M.D., Dept. of Surgery, Div. of Orthopedics, Emory University School of Medicine, Atlanta, Ga., "Lateral Approach to the Upper Cervical Spine for Anterior Fusion," Southern Medical Journal 59:879-883(August)1966.**

The well-described and established anterior approaches to the midcervical spine by way of planes of dissection medial to the carotid sheath are applicable in most cases requiring operations upon the anterior cervical spine and fusion. Despite the numerous advantages of this approach and its wide applicability, proximal exposure is not adequate to meet the demands of some unusual situations. The classic approach of Arnold Henry to the vertebral artery by eversion of the sternocleidomastoid and an approach through dissection planes posterior to the carotid sheath have been used successfully in two cases requiring proximal exposure with two year follow-ups. This approach may have applicability to a variety of other situations. With so beautiful a guide as Mr. Henry's eloquent descriptions and lucid illustrations, and with some hours of review with a standard anatomic text of usually a much more boring literary style, this approach should present no particular problem, but an interesting challenge to the orthopedist.

**Van Duyn, John, M.D., Doctors Building, Columbus, Ga., "A New Procedure for Stenosis of the Lower Lacrimal Canaliculus," Southern Medical Journal 59:906-909(August)1966.**

Lacerations of the lower eyelid that pass through the lower lacrimal canaliculus are one of the most common forms of trauma to the lid and appear to be on the increase. When this injury is followed by stenosis, there is always epiphora since most of the drainage of tears from the eye is by the lower canaliculus.

When the laceration is such that a section of the canaliculus is destroyed, and especially if this is in the medial half of the duct, efforts at correction, directed at the restoration of continuity by reconstruction of the duct (usually by the use of grafts and/or prolonged splinting), have been disappointing.

Such obstructions in the lower canaliculus have been called "the most challenging and at the same time the most frustrating of all lacromal system lesions" (Fox).

In the reported case the missing medial section of the lower canaliculus in a 45-year-old male was replaced by transplanting the corresponding section of the upper canaliculus. This was effected by means of overlapping palpebral flaps, the flap carrying the substitute section of upper canaliculus being placed posteriorly.

Epiphora did not recur after three and one-half years.

It is believed that the success of the operation is due to the fact that the function of the so-called lacrimal pump (Jones and Boyden) is not impaired.

**Cooper, R. D., Jr., M.D.; Izenstark, J. L., M.D.; Branyon, D. L., Jr., M.D.; Bowen, E. G., M.D., and Weens, H. S., M.D., Emory Univ. School of Medicine, Atlanta, Ga., "Isotopic Placentography of Placental Scanning?," Radiology 87:291-297(August)1966.**

Placental scanning may be performed using only 4-5  $\mu$ c of  $^{131}\text{I}$  with currently available scanners which have at least a three-inch detector crystal and which are modified by an open flat field collimator.

A clinical comparative study was done in which 27 third trimester bleeding patients had predelivery localization of the placenta by scanning technique and point count localization. The placental site was confirmed at delivery. Analysis of the results reveal that clinical accuracy of scanning techniques and point count localizations are similar but that scanning produces better anatomic depiction of the placental location. This eliminates calculation and allows easy interpretation of the placental site.

**Greenblatt, Robert B., M.D., and Coniff, Robert F., M.D., Dept. of Endocrinology, Medical College of Georgia, Augusta, Ga., "Glands Not to Monkey With," The New Physician 15:223-226(August)1966.**

Endocrine therapy had a poor beginning because of the unavailability of effective endocrine preparations. Subsequent progress has provided many natural and synthetic hormones, making an understanding of both their usefulness and effectiveness imperative. Hormones may be used to correct endogenous deficiencies or to achieve certain desired physiologic effects, and an awareness of basic endocrine concepts is essential to the proper use of these drugs.

Pituitary hormones, with the exception of ACTH, are species-specific so that animal preparations are not only generally ineffective but may lead to antibody formation. Human pituitary hormones are effective but in short supply. In general, thyroid hormone preparations are rather widely abused and should be employed only when a demonstrable need exists. Empiric therapy with thyroid can result in a syndrome of temporary iatrogenic hypothyroidism when the drug is discontinued. Androgens have excellent anabolic and mood-elevating properties in menopausal women but, in too large a dosage or in sensitive women, can result in hirsutism or virilism. Estrogens and progestogens are currently employed in a wide assortment of gynecologic disorders and as contraceptives. Despite fears, there is no objective proof of carcinogenic properties. Their main hazard is uterine bleeding, but paradoxically they are an

effective means of controlling atypical uterine hemorrhage. Finally, the excessive clinical application of ACTH and the glucocorticoids provides some of the most tragic instances of iatrogenic illness. Only respect for and an understanding of these potent drugs will prevent their misuse.

**Ridley, John H., M.D., Piedmont Hospital, Atlanta, Ga., "Appraisal of the Goebell-Frangenheim-Stoeckel Sling Procedure," American Journal of Obstetrics and Gynecology 95:714-721(July)1966.**

The correction of stress urinary incontinence in the female is principally surgical. Since the chief etiology of stress urinary incontinence is the structural weakness brought on by obstetric trauma, the chief method for correction is that of repair and reconstruction.

Surgical considerations for correction of stress urinary incontinence may be divided into three categories.

1. The Kelly, or modifications thereof as described by Kennedy.

2. Sling or strap procedure. Employment of remote tissues in the repair i.e. fascia, muscle or tendon or the use of foreign materials as mersileme, dacron, etc.

3. The Marshall-Marchetti-Krantz Procedure.

Reasons for favoring the sling type of procedure are: (1) The sling procedure is not technically difficult. Any needed vaginal repair can be performed at the same time that the sling is placed, even with further para urethral application to augment the primary procedure. (2) The over-all results have been more successful with the sling procedure in this series. (3) The sling procedure is the "ultimate effort" after other techniques have been tried and failed. In those cases where the Marshall-Marchetti-Krantz procedure has failed, the Goebell-Frangenheim-Stoeckel procedure may be done when a repeat Marshall-Marchetti-Krantz procedure may be most difficult.

The over-all results of the sling procedure have been very satisfactory. The fascia lata sling has been favored above all other. The use of mersileme as a sling has not been satisfactory.

**Wender, Charles, M.D., and Acker, Joseph E., Jr., M.D., Dept. of Internal Medicine, Emory University Clinic, Atlanta, Ga., "Constrictive Pericarditis Associated With Hemangioma of the Pericardium," American Heart Journal 72:255-258(August)1966.**

The fourteenth case of hemangioma involving the pericardium and the second of multiple hemangiomas involving this structure is reported. Unique features include associated involvement of the thymus and pleura with tumor and pericardial constriction. Pericardiectomy eliminated the pericardial constriction; however, bilateral thoracotomies with therapeutic obliteration of both pleural spaces were necessary to prevent re-



## ABSTRACTS / Continued

current intrapleural hemorrhage. The association of intrapericardial hemorrhage and ultimate pericardial constriction is briefly reviewed.

Witherington, Roy, M.D., and Rinker, J. Robert, M.D., Dept. of Surgery, Div. of Urology, Medical College of Georgia, Augusta, Ga., "Percutaneous Needle Puncture in the Diagnosis of Renal Cysts," *The Journal of Urology* 95:733-737(June)1966.

The differential diagnosis between renal cyst and tumor continues to be a problem. Percutaneous needle puncture is a simple and expedient means to differentiate these lesions.

If fluid is aspirated from a lesion, radio-opaque medium is injected and x-rays obtained. With a smooth walled cyst, surgery isn't advocated. If the cyst wall is irregular by x-ray, or if bloody or chocolate-colored fluid should be obtained by puncture, exploration is indicated. If no fluid, or only blood, should be obtained, exploration is indicated. The cyst fluid should be examined cytologically to rule out tumor arising from cyst wall.

This diagnostic modality is reserved for patients over 50 years of age where the mass is easily discernible. There should be no obvious evidence of malignancy such as hematuria or distant metastasis.

Thirty-two punctures in 31 patients yielded fluid in 27 instances and no fluid in five instances. In one cyst, the fluid was chocolate-colored; and exploration revealed renal cell carcinoma. Of the five patients where punctures yielded no fluid, four were explored, with renal cell carcinoma being found in three and cyst in one. One case was not explored because of moribund condition.

It is believed that more frequent use of this procedure will prevent many unnecessary explorations for renal cyst. Thus far, there is no clinical evidence that spread of tumor has been caused by needle puncture in those cases where renal tumor was present.

## AMA VOLUNTEER PHYSICIANS FOR VIETNAM

AMA Volunteer Physicians for Vietnam is a program for supplying medical care to the civilian population of South Vietnam through the volunteer services of U.S. physicians.

It is administrated by the American Medical Association and financed by the United States Agency for International Development (USAID).

Physicians sent to South Vietnam under the program serve a 60-day tour of duty at one of 16 provincial civilian hospitals. The volunteer receives only his transportation and an expense allowance of \$10 a day; otherwise his services are entirely unpaid.

At the hospitals the volunteers work with teams of military physicians and corpsmen. These teams, assigned to USAID for service in provincial civilian hospitals, provide continuity in the volunteer program.

Twenty-four to 32 physicians are needed every month to keep hospital staffs at full strength. Most needed are general practitioners, internists, general surgeons and orthopedic surgeons. As of June-July, 1966, the greatest demand is for general and orthopedic surgeons to treat war wounded civilians. Small numbers of specialists in the fields of chest diseases, ophthalmology, otolaryngology, radiology and psychiatry are needed from time to time. Other specialists cannot be used at present but inquiries are invited in anticipation of future demands. Because of conditions in Vietnam, only male physicians are accepted. Non-physicians are not recruited.

### The Background

South Vietnamese authorities have asked the United States government to encourage American physicians to volunteer their services to Vietnamese civilians.

Out of this request grew a program financed by the U.S. government through the State Department's Agency for International Development (AID). Created to recruit U.S. physicians for volunteer 60-day tours of service at Vietnamese civilian hospitals, the program was at first administered by People-to-People Health Foundation, Inc., with the American Medical Association assisting in recruitment. At this point the program was called Project Viet-Nam.

After successfully implementing Project Viet-Nam on a pilot basis, People-to-People Foundation asked that the program be turned over to some other responsible

agency, preferably the AMA. At the invitation of the Agency for International Development, the AMA assumed administrative responsibility on June 30, 1966, when the contract between the USAID and People-to-People Health Foundation, Inc. terminated. Under the aegis of the AMA, the program is known as AMA Volunteer Physicians for Vietnam.

### The Challenge to the Physician

An American physician faces challenges in Vietnam that most U.S. doctors see only in textbooks. Important causes of death in South Vietnam are malaria, tuberculosis, intestinal parasitism and other intestinal diseases, pneumonia, meningitis, typhoid fever, and a wide range of war wounds caused by mines, booby traps, small arms fire, and air or artillery bombardment. Thousands of civilians need treatment and rehabilitation after war injuries.

Diseases causing disability throughout the population include trachoma (four-fifths of the people infected at one time or another), leprosy, bacillary and amebic dysentery, smallpox, and nutritional disorders.

South Vietnam has about 120 hospitals, of which 101 serve civilians. All are overloaded; at times, two or even three patients have been accommodated in a single bed.

Physicians serving through AMA Volunteer Physicians for Vietnam are placed in government-operated hospitals in rural areas, where the need is greatest. All are in so-called pacified regions where the Viet Cong do not routinely conduct military operations in the open, although they are presumed to be nearby at all times.

Military teams in the civilian provincial hospitals will each comprise three medical officers, one administrative officer, and 12 enlisted men (corpsmen). Their responsibility will be for the civilian population in the province to which they are assigned.

### Recruitment

To be accepted as a volunteer the physician must be in good health and not more than 55 years old. No dependents may accompany the volunteer, even if the dependent is medically qualified.

A passport and visa are required of all volunteers going to Vietnam, and assistance is given the physician in obtaining them. The volunteer also must have a



certificate of vaccination against smallpox and inoculation against cholera, received in the last four to six months. Immunization against plague, typhoid, tetanus, typhus and polio are recommended by the World Health Organization.

Transportation is supplied from the physician's home to Vietnam and return. A standard baggage allowance of 44 pounds, plus an additional 22 pounds, is permitted.

Housing is provided in Vietnam in available hotels or apartments. Each volunteer physician receives an expense allowance of 10 dollars a day. Expenses connected with passport, visa and immunization are paid by USAID through AMA Volunteer Physicians for Vietnam. Each volunteer is covered, while in Vietnam, by a

\$50,000 all-risk insurance policy at no expense to himself.

Upon arrival in Saigon the volunteer will be met by the Field Director of AMA Volunteer Physicians for Vietnam or an associate, and directed to the proper destination. The Field Director also assists hospital staffs with supply and logistical problems.

Information about the program may be obtained by contacting:

*AMA Volunteer Physicians for Vietnam  
American Medical Association  
535 North Dearborn Street  
Chicago, Illinois 60610*

## HIGHLIGHTS OF THE ACTIONS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING, AUGUST 28, 1966 – ATLANTA

*This summary is being sent you so that MAG Officers and Councilors may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.*

**Heart, Cancer and Stroke Regional Medical Program** for Georgia was discussed by MAG Medical Education Committee Chairman George Dillinger; Emory University School of Medicine Dean Arthur Richardson; and Medical College of Georgia President Harry O'Rear. Progress in preparing the "grant application" by the Advisory Group was reported and further study was given to the selection of the grant Applicant. Feasibility of MAG serving as grant Applicant considered but no decision reached.

**MAG Field Service Representative** was appointed as an addition to the Association Headquarters Office Staff per the recommendation of the 1966 MAG House of Delegates. Mr. William V. Wallace of Montgomery, Alabama, formerly Executive Secretary of the Medical Association of the State of Alabama, was employed effective September 1, 1966. Mr. Wallace's duties will consist of liaison between MAG Headquarters and the Association component county medical societies.

**Labeling of Prescription Drugs** by the pharmacist filling the prescription was presented for a policy decision by MAG at the request of AMA. The Executive Committee voted in favor of the policy of labeling prescription drugs at the discretion of the individual physician prescribing the drug.

**Establishing an "Association Foundation"** to receive grants, bequests and donations for the purpose of medical education and research was referred for investigation to a special committee appointed by MAG President Walter Brown. This committee will report to Executive Committee after studying other state medical association Foundations designed for this same purpose.

**Representation on the State Board of Health** by a Hospital Administrator was suggested by the Georgia Hospital Association because of the Board's activity in the area of hospital regulations. This matter was referred to the MAG Legislative Committee to consult with the

MAG Hospital Activities Committee and report back recommendations to Executive Committee.

**County and District Medical Society "Medical Review Committee"** progress report indicating the initiating of six County Society Medical Review Committees and eight District Society Medical Review Committees was received for information.

**Financing MAG Annual Sessions**, which is under study by a special MAG committee, was discussed on the basis of a survey of methods used by other state medical associations. The committee is investigating ways and means of obtaining sources of income other than the sale of exhibit booth space.

**Lease of Space in MAG Headquarters Office Building** to the State Department of Family and Children Services for administration of the new drug program was approved with certain stipulations for further lease negotiation with the Department. It was noted that the Regional Medical Program on Heart, Cancer and Stroke was also interested in the same space for rental. *(See additional information following:)*

*Résumé of the Actions of the  
MAG Executive Committee of Council  
Phone-Call Conference Meeting, September 2, 1966*

**Lease of Space in MAG Headquarters Office Building** per a proposed contract with the State Department of Family and Children Services was discussed on the basis certain stipulations made by Executive Committee at its August 28, 1966, meeting. While it was generally agreed that these stipulations could be "worked out" with the Department, certain members of Executive Committee presented their sentiments about making this same space available to the Regional Medical Heart Disease, Cancer and Stroke program.

After further discussion of this matter, the Executive Committee voted to inform the Department with regret that the leasing of space be turned down—as the Association may have other use for this same space in connection with the Regional Medical Heart Disease, Cancer and Stroke program. The Executive Committee further recommended that the Association proceed to move toward becoming fiscally responsible as Applicant for the Regional Medical Heart Disease, Cancer and Stroke program.





DEATHS

**Lloyd E. Wilson**, 87, of Atlanta, a practicing physician in Bowdon, Georgia, for 56 years, died August 8, 1966, in a private hospital.

A graduate of old Bowdon College and Emory Medical College, Dr. Wilson was a deacon and Sunday School teacher at the Bowdon Baptist Church, a member of the Bowdon Masonic Lodge No. 206, and a trustee of the Bowdon public schools. He retired eight years ago and moved to Atlanta, where he was a member of the First Baptist Church.

Born in Heard County, he was a member of the American Medical Association and the Medical Association of Georgia.

Survivors include two sons, Emmett G. Wilson, Powder Springs, and John A. Wilson, College Park, and two daughters, Mrs. R. E. Kitchens, Atlanta, and Lt. Cmdr. Edith C. Wilson, Navy Nurse Corps, Chelsea, Mass.

**James A. Johnson, Jr.**, Atlanta, died July 11, 1966, at Emory University Hospital of cancer. Dr. Johnson was born in Manchester, Georgia, and attended Emory University and Emory University School of Medicine. After serving in the U.S. Army Medical Corps in Okinawa in World War II, he returned to Manchester and was in general practice with his father for approximately ten years. During this time Dr. Johnson was active in civic affairs. He served as Mayor of Manchester and in 1948 was selected by the State Junior Chamber of Commerce as the Outstanding Young Man of the Year.

In 1955 Dr. Johnson left general practice and began his psychiatric training first at Milledgeville State Hospital, then Boston State Hospital and subsequently at Emory. After completion of his training, he joined the faculty of the Department of Psychiatry at Emory and became an Assistant Professor.

Dr. Johnson was very interested in group psychotherapy and was in charge of that part of the psychiatric teaching program. In 1963 his book, *Group Therapy: A Practical Approach*, was published by McGraw-Hill.

Dr. Johnson was active in the Southeastern Group Psychotherapy Society and was a Past President. He was a member of the American Psychiatric Association, American Medical Association, Southern Medical Association, Georgia Psychiatric Association and the American Group Psychotherapy Association.

Dr. Johnson is survived by his wife, Mrs. Mary Martha Johnson, and four sons.

PERSONALS

Fifth District

**A. H. Letton**, Chief of Staff of the Georgia Baptist Hospital, Atlanta, spoke to the Georgia Vocational Rehabilitation Staff Training Conference, August 18, 1966, at Jekyll Island. Dr. Letton's topic concerned the every-increasing role of rehabilitation in the care of cancer victims.

Ninth District

**Jerald L. Watts** has joined **Charles H. Little** in the practice of orthopedic surgery in Gainesville. With the addition of Dr. Watts to the community, Gainesville now has 50 doctors.

Tenth District

**Daniel H. G. Glover** of Jesup, who has served as District Director of Public Health for five Georgia counties for 11 years, resigned his position effective September 2, 1966. Dr. Glover has assumed the duties of director of the Federal Maternity and Infant Care Project No. 506 in Augusta. He will cover 13 counties in that section, and will be associated with the Richmond County Health Department, the Medical College of Georgia and Talmadge Memorial Hospital.

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*See page 464*

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**Cover**

Illustration courtesy of the American Medical Association, Chicago.



only one in the morning ☒

and one in the evening ☐



# PHYSICAL THERAPY IN CHRONIC BRONCHITIS AND EMPHYSEMA IN NORMAL AND OXYGEN-ENRICHED ATMOSPHERES\*

Albert Haas, M.D.; Pierre Gayrard, M.D., and Fernando Chacon, M.D.,  
*New York, New York*

- Methods of therapy are described which should prove to be valuable additions to the present-day treatment of patients with obstructive pulmonary disease.

TREMENDOUS STRIDES have been made since World War II in bringing the advantages of modern rehabilitation methods to increasing numbers of disabled persons. Little, however, has been done until recent years to bring the modern philosophy of rehabilitation and its methods to patients suffering with obstructive pulmonary diseases.

One out of every 14 workers receiving social security benefits because of total and permanent disability is disabled by emphysema. In 1960 alone, 12,372 workers with emphysema were classified under the Social Security Disability benefits program as being totally and permanently disabled.<sup>1</sup>

On the basis of recent surveys, it is estimated that more than a million people in the United States suffer from emphysema and that emphysema as a disease entity is continuing to increase (United States Public Health Surveys, 1959 and 1960). Further studies indicated that emphysema was second only to coronary diseases in disabling the nation's workers between the ages of 50 and 65.

The progressive, crippling character of this disease presents serious socioeconomic problems. Emphysema patients are apt to become irregular in their work attendance. Ultimately, they may have the

greatest difficulty in meeting vocational demands, particularly speed and endurance as well as travel, and may have to abandon their vocations. The point may be reached where they are unable to attend to their own daily activities independently. This crippling stage is most often reached in those over 40. This is one of the foremost factors of the disease from a socioeconomic viewpoint because it is the population over 40 that is normally most stable and economically productive. Breadwinners may be abruptly incapacitated; families of patients are disrupted financially, socially and psychologically, and their future prospects severely threatened. Limitations of current treatment are such that it offers no deterrent to the impact of the disease socially and economically. To date, clinical management of patients with moderate or advanced pulmonary emphysema has not been able to cope with the total problem. Although numerous studies have been undertaken on this disease entity, they have not made any great advances in the clinical management of these patients.<sup>2</sup> Treatment to date has been largely symptomatic, involving chiefly the use of bronchodilators, expectorants and IPPB (Intermittent Positive Pressure Breathing), as well as broad spectrum antibiotics for the control of acute respiratory infections. Antibiotics have undoubted value in this area, but they do not alter the existing pathology that is irreversible. Further, patients hospitalized in the early stages, who do not yet manifest the crippling effects of the disease, are likely to receive treatment only for acute concomitant infections. The most striking shortcoming has been the

*From the Department of Physical Medicine and Rehabilitation, School of Medicine, New York University, New York, New York.*

*\*This paper is based on the findings of two research studies: "Rehabilitation of Patients with Emphysema" supported by O.V.R. Research Grant SP-175 and "The Effect of Living in an Enriched Oxygen Atmosphere on the Rehabilitation of Patients with Emphysema and Neuromuscular Diseases" supported by O.V.R. Research Grant RD-1315-M.*

*Presented at the Medical College of Georgia, Augusta, Georgia, May, 1966.*



absence of applied rehabilitative measures designed to formulate a complete program of physical medicine procedures and social and vocational assistance.<sup>3</sup>

Organization of Rehabilitation Program

In order to establish a comprehensive rehabilitation program and to assess the role of the physiatrist in the management of patients with chronic obstructive lung disease, a study was organized in the Department of Physical Medicine and Rehabilitation of New York University in which extensive and vigorous rehabilitative measures were applied.<sup>4</sup>

Two groups of patients were set up: an experimental group of 127 and a control group of 50. The goal of this research was to: (1) determine the role of modalities such as positional postural drainage to free the airways from secretions, (2) determine the extent to which breathing exercises are useful in improving patterns of breathing and strengthening the respiratory muscles, (3) decrease the energy cost of breathing, (4) improve pulmonary ventilation, and (5) rehabilitate the patient vocationally for possible resumption of work.

Patient Population

To date a total of 645 patients have been admitted to this program. This number does not include the control group. Seventy-eight percent of the patients were outpatients and the rest were treated as inpatients. The ratio of males to females was nine to one. Their age ranged from 39 to 70. About equal parts were professional, skilled and semi-skilled workers. Most of the patients were smokers (from ten cigarettes a day to three packs a day); only a fraction of one percent had never smoked. However, about 27% had discontinued smoking either because of the severity of symptoms or because of medical advice. The patients were referred by local medical doctors, hospitals and by municipal and private agencies.

TABLE I

AVERAGE VALUES FOR PULMONARY FUNCTION IN 513 MALE PATIENTS WITH OBSTRUCTIVE PULMONARY DISEASE BEFORE AND AFTER REHABILITATIVE MEASURES

	Before	After
Respiratory Rate	21/min	17/min
Tidal Volume	.390 L	.420 L
Minute Ventilation	7.990 L	7.140 L
Vital Capacity	78%	78%
Residual Volume	238%	210%
Total Lung Capacity	125%	129%
Residual Volume/Total Lung Capacity	45%	44%
Maximum Breathing Capacity	40%	43%
Timed Vital Capacity		
First Second	35%	35%
Second Second	45%	58%
Third Second	58%	67%
Maximum Mid-Expiratory Flow	30 L/min	45 L/min

In addition to the afore-mentioned patient groups, a third group was chosen for the purpose of determining the effect of an oxygen enriched atmosphere on the patients' pulmonary function, blood gases, and mental and physical status. A special room with an oxygen enriched atmosphere was constructed. The room was sealed off to avoid ventilation from the outside and was fitted with two alternately-functioning oxygen producing plants which worked on the following principle: room air from the outside was compressed over an organic chemical which temporarily reversibly absorbed the nitrogen; the oxygen-rich air was then selectively blown into the room. The machines were capable of maintaining concentration of up to 40% of oxygen under normal atmospheric pressure.

Laboratory Findings

The pulmonary function tests of the patients referred to us are shown in Table I.\* As may be seen,

TABLE II

AVERAGE ARTERIAL BLOOD GAS COMPOSITION IN 100 MALE PATIENTS WITH OBSTRUCTIVE PULMONARY DISEASE BEFORE AND AFTER REHABILITATIVE MEASURES

Condition	Oxygen Saturation Percentage		Carbon Dioxide Tension (mm Hg)		pH	
	Rest	Work	Rest	Work	Rest	Work
Before Rehabilitation:						
Sedentary Work	94	89	42	44	7.38	7.38
Stair Climbing	94	85	42	49	7.38	7.37
After Rehabilitation:						
Stair Climbing	95	87	42	44	7.38	7.38
Pulmonary Diffusing Capacity	Before 8.5 ml/min/mm Hg		After 8.5 ml/min/mm Hg			

the pulmonary function tests did not change significantly except for a decrease in respiratory rate and an increase in tidal volume.

One-hundred of the subjects were tested for arterial blood gas composition before and after rehabilitation measures (Table II). Blood gas studies do not indicate significant changes in the oxyhemoglobin saturation. However, there was a significant decrease in carbon dioxide tension during stair-climbing.

Treatment Procedures

The patients were given a one-week indoctrination in rehabilitative measures consisting of postural drainage and therapeutic breathing exercises which they were encouraged to practice at home at least twice daily. Postural drainage was preceded by the inhalation of bronchodilator introduced with the intermittent positive pressure breathing valve. The patients were then positioned according to the dis-

\* Results were calculated by the regression equations of Baldwin, et al.<sup>5</sup>

tribution of the bronchopulmonary segments (Figure 1, A and B). The physical therapist tapped the patients' chests and encouraged them to cough in order to assist gravity in draining the appropriate segments.

Eight patients with bronchiectasis and 12 patients with obstructive diffuse emphysema were studied to measure sputum production with and without postural drainage.<sup>4</sup> The patients served as their own control group. Sputum production was measured during a 24 hour period in which medication but no postural drainage was given. During the next 24 hour period, postural drainage was added to the regimen and sputum production again measured. It is evident (Graphs 1 and 2) that there was an increase in sputum production with postural drainage; i.e., from 115 to 240 cc in the bronchiectasis group (Graph 1) and from eight to 45 cc in the diffuse type of emphysema (Graph 2). The bacterial population and texture of the sputum were similar in both instances.

The therapeutic breathing exercises consisted of (1) pursed-lip breathing (Figure 2), (2) isometric contraction of the diaphragm against gradually increasing abdominal weights (one to ten pounds), (3) isometric contraction of the muscles of respiration, and (4) resistive exercises designed to strengthen the muscles of expiration, such as candle and bottle-blowing.<sup>6</sup> The patients continued these modalities during the hospital treatment and were encouraged to practice them at home in order to change their breathing pattern as much as possible.<sup>7</sup> Following discharge from the program, the patients were followed and re-examined in three to six-month intervals.

For the patients who were treated in the oxygen room, the rehabilitative measures were similar to those of the other groups, but these modalities and other paramedical treatment were carried out at their bedsides. As may be seen from Table III, the findings of the pulmonary function tests in this group of pa-

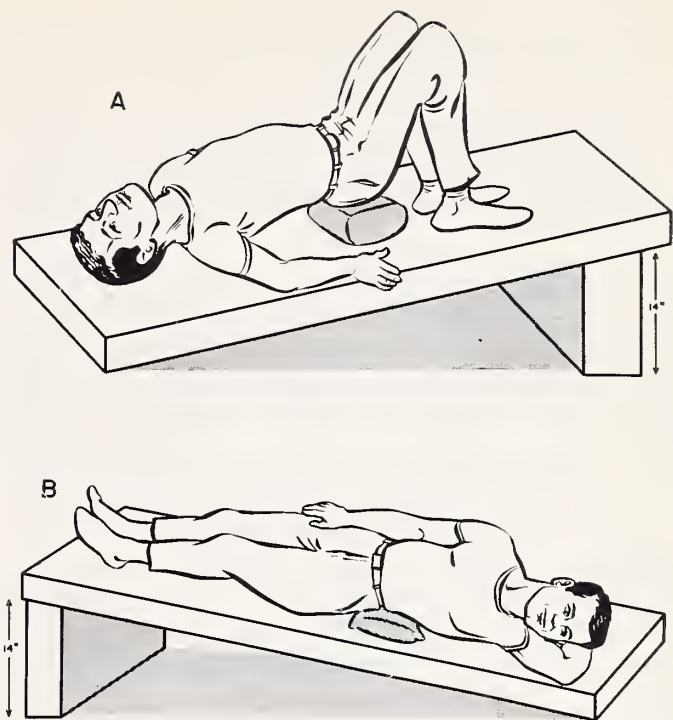


FIGURE 1  
A and B: Some basic exercises in postural drainage.

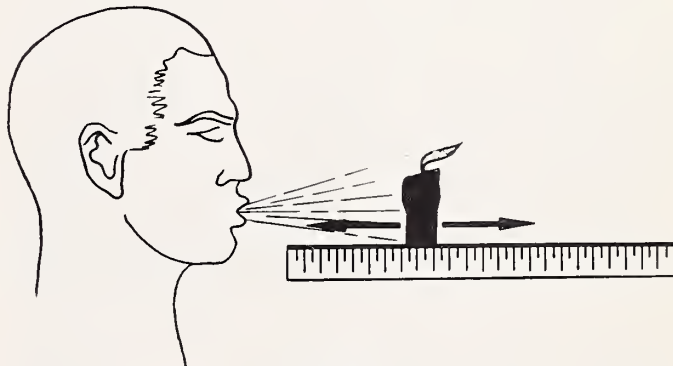
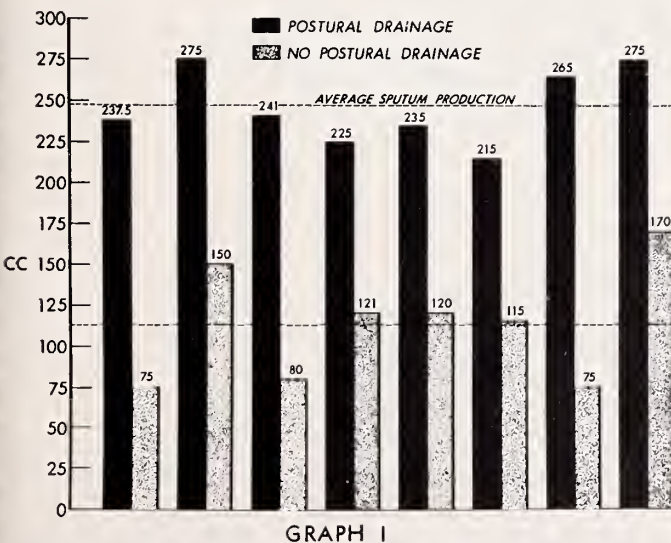
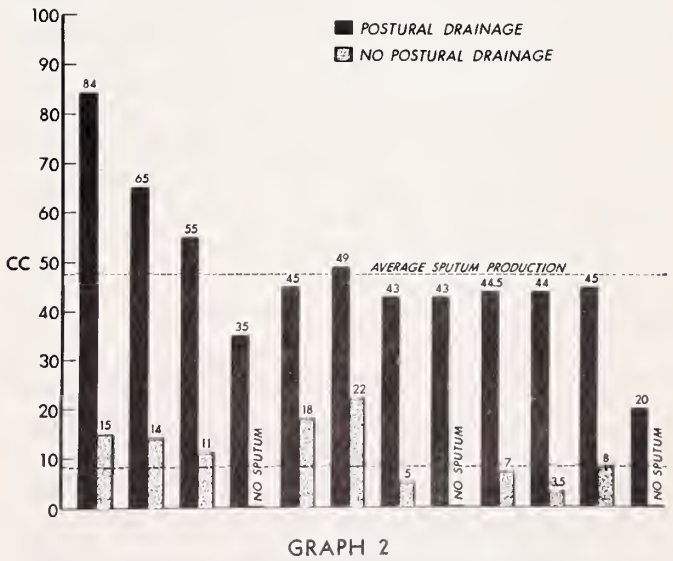


FIGURE 2  
Candle blowing to enhance pursed-lip breathing.



Sputum production with and without postural drainage in eight bronchiectatic patients.



Sputum production with and without postural drainage in twelve obstructive pulmonary emphysema patients.



TABLE III

AVERAGE LUNG VOLUMES AND CAPACITIES\* IN LUNG FUNCTION BEFORE AND AFTER TREATMENT IN AN OXYGEN ENRICHED ATMOSPHERE

LUNG VOLUMES						
Before			After			
	Pre-dicted	Ob-served	Pre-dicted	Ob-served	Pre-dicted	
IC	2.500	1.800	71%	2.500	2.160	86%
ERV	0.830	0.946	112%	0.830	0.920	111%
VC	3.340	2.740	82%	3.340	3.100	92%
FRC	2.000	3.670	183%	2.000	3.530	176%
RV	1.170	2.720	233%	1.170	2.610	223%
TLC	4.510	5.460	121%	4.510	5.700	126%

		Before		After	
		Predicted	Observed	Predicted	Observed
RV/TLC		35%	50%	37%	46%
FRC/TLC		60%	67%	60%	62%

AIR FLOWS				
		Predicted	Observed	Observed
MBC		90 L	42%	90 L
TVC				84%
1st	Second	83%	43%	83%
2nd	Second	87%	62%	87%
3rd	Second	93%	73%	93%
Max. Mid-Exp.				
Flow Rate			24.5 L/min	26.7 L/min
AVI	MBC%	1 to .9	0.6	1 to .9
	VC%			

VENTILATION			
Respiratory Frequency		19/min	19/min
Tidal Volume		0.594	0.699
Minute Volume		11.290	13.280
Oxygen Consumption		.265 L/min	.272 L/min

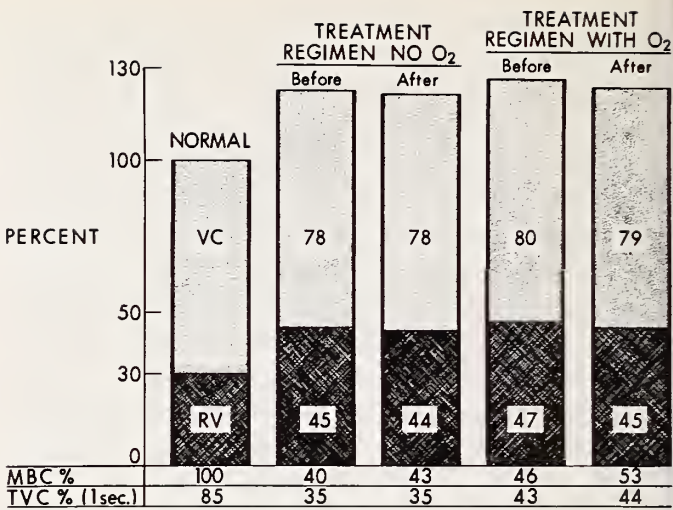
\* Expressed in liters.  
Abbreviations: IC—Inspiratory Capacity; ERV—Expiratory Reserve Volume; VC—Vital Capacity; FRC—Functional Residual Capacity; RV—Residual Volume; TLC—Total Lung Capacity; MBC—Maximum Breathing Capacity TVC—Timed Vital Capacity; AVI—Air Velocity Index.

tients were similar to those of the ambulatory group (Graph 3). Here again, there was no significant change except for increased tidal volume.

Table IV indicates the status of the arterial blood gas composition. As may be seen, the oxyhemoglobin was fully saturated at rest and fell only slightly during the exercise of daily activities. There was no change in carbon dioxide tension.

Another difference in the program for the oxygen room patients was that postural drainage and breathing exercises were administered at a slower pace, starting with 15 minutes, three times daily, and gradually increasing to 45 minutes. The atmosphere of the oxygen room was regulated to maintain the patient's arterial blood oxygen saturation level at 95% at rest and at 92% to 94% during therapeutic exercises. This degree of oxyhemoglobin saturation was made possible by maintaining the oxygen concentration of the room's atmosphere at 27% to 29%.

Because of the danger of a possible rise in blood carbon dioxide level under oxygenation, determination of this factor was made daily by the Astrup micro method.<sup>8</sup>



GRAPH 3

Residual volume (RV) in relation to total lung capacity (TLC) and maximum breathing capacity (MBC) and the percent of the observed vital capacity in one second (VC) are also illustrated.

TABLE IV				
AVERAGE VALUES IN BLOOD GAS COMPOSITION DURING REST AND WORK WITHOUT AND WITH TREATMENT IN AN OXYGEN ENRICHED ATMOSPHERE				
		Without		With
O <sub>2</sub>	87%	81%	95%	94%
PCO <sub>2</sub>	48 mm Hg	51 mm Hg	46 mm Hg	51 mm Hg
pH	7.35	7.35	7.34	7.32
Pulmonary Diffusing Capacity*	8.5 ml/min/mm Hg		7.1 ml/min/mm Hg	

\* Average value in our laboratory for a normal individual is between 15 and 30 ml/min/mm Hg.

TABLE V		
STATUS OF EXPERIMENTAL PATIENTS (POST DISCHARGE) AND CONTROL OUTPATIENTS AT TERMINATION OF STUDY		
Status	Percentage of Experimental Group (127 Patients)	Percentage of Control Group (50 Patients)
Still in hospital	5.0	6.0
Returned to job; still work	4.0	None
Awaiting job placement	8.5	None
In workshop evaluation	4.5	None
Rehospitalized	18.5	18.0
Living in nursing home	4.0	None
Rehospitalized; died	18.5	42.0
Died in nursing home	12.0	None
Returned to self-care	10.0	None
Lost for unknown causes	15.0	34.0

Table V indicates the post-discharge status of 127 experimental patients and the control group of 50. It is important to note that 17% of the experimental patients returned to or were able to resume gainful employment. More important, the mortality rate in the experimental group was 12% lower than in the control group.

In analyzing the collected data, it is evident that the above-described rehabilitative procedures with ultimate vocational retraining are valuable addenda to the present-day treatment of patients with obstructive pulmonary disease. Opinion as to the value of

oxygen therapy for patients with obstructive pulmonary disease is divided, if not controversial, since oxygen therapy will enhance carbon dioxide retention. Our study showed that if oxygen is administered on a carefully regulated basis with daily analysis of blood carbon dioxide level, oxygen therapy can be safe.<sup>9</sup> And it is advisable to administer it continuously rather than periodically or not at all.

In order to maintain adequate oxygenation, a high flow of oxygen is not necessary. A flow of two to three liters per minute of 100% oxygen will maintain an oxyhemoglobin saturation of at least 94% in most patients. These findings are also supported by the patients placed in the oxygen enriched atmosphere. Cautiously administered oxygen therapy is a necessary step forward in maintaining the energy requirements of therapeutic exercises.

As is indicated from this study, if postural drainage is applied regularly and positioning according to the distribution of the bronchopulmonary segments is observed, the results can be gratifying. It is paramount that before postural drainage, the patient be prepared with bronchodilator and eventually with mucolytics. Bronchodilators have already been accepted as important medications in relieving obstruction. However, the value of the mucolytic agent has to be further investigated.

A further observation—and a surprising one—was the patients' unfamiliarity with the proper use of the inhaler—gas propelled or manual—in spite of the fact that they had been taking medication by this method for long periods of time prior to admission.

A definite statement as to the success of treating patients in an oxygen enriched atmosphere cannot yet be made since the follow-up period is too short to determine whether the improved clinical status reached by these patients while living in an enriched oxygen atmosphere can be maintained once they have been discharged.

The conclusion may be drawn that rehabilitative measures, such as postural drainage, exercises in the low energy cost field and breathing exercises, are

better tolerated in the oxygen enriched atmosphere and, most important, no ill effects have been observed. A four to ten percent increase in the oxygen saturation of the room's atmosphere appears sufficient to maintain approximately normal arterial oxygen saturation; i.e., 95% at rest and 94% during activities.

Although there is clinical improvement following rehabilitation, this improvement is not discernible from the pulmonary function tests. This could be attributed to the fact that spirometric tracing is only a rough estimate and that a plus/minus 20% error exists and should be taken into consideration. It is evident that these treatment modalities are not only time-consuming but also costly, involving expensive laboratory and therapeutic equipment and stand-by physical therapist. From a medical economic point of view, it would not be possible to offer such treatment in a private office. However, the treating physician can send the patient to a rehabilitation center where all facilities are at hand and where the patient can still be under his clinical supervision.

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### SEPTEMBER SCIENTIFIC PAPER WRITTEN BY FORMER STUDENT AT THE MEDICAL COLLEGE OF GEORGIA

The scientific paper, "Reaction to Hymenoptera Insect Stings," by Walter McEarchern, M.D., which appeared in the September, 1966, issue of the *Journal of the Medical Association of Georgia*, neglected to state that, before assuming his internship at Brooke General

Army Hospital, San Antonio, Texas, Dr. McEarchern was a 1966 graduate of the Medical College of Georgia, Augusta. The above mentioned scientific article was Dr. McEarchern's senior medical paper and received a high rating from the Department of Medicine.



# GANGRENE OF THE HEEL WITH DIABETES. ARTERIAL RECONSTRUCTION, THE CONSERVATIVE APPROACH.

Robert I. Lowenberg, M.D., *Atlanta*

- Medical and surgical problems presented by this difficult group of patients are discussed in depth.

**T**WENTY YEARS AGO, at a University Hospital, a surgical resident treated a diabetic male patient with gangrene of the heel. Everything then available, including sympathectomy and local applications of red cell paste were used,<sup>1</sup> but to no avail. The patient lost his limb. This experience was traumatic to the youthful and idealistic resident treating this patient. Literary search, inquiry, and much soul searching ensued. The result: the author went into vascular surgery to seek further solutions to this tragic problem. In the past and even today, there is a paucity of literature on this subject. An example of this is contained in a beautiful monograph by Dr. Edward A. Edwards documenting 19 cases of gangrene in the lower extremities which lists only two cases of gangrene of the heel.<sup>2</sup> Diabetic gangrene of the heel today remains a most difficult problem, and in many instances, limbs are still lost. We do, however, have additional aids at our disposal. At present, we have both a better understanding of how the lesions under consideration develop and their hemodynamic pathophysiologic aspects. The formation of collateral circulation relative to occlusive disease has been documented and graphically recorded. Moreover, we have medications and surgical techniques which are effective so that lesions of this nature, today, are not to be considered merely didactic but are to be considered practical.

An understanding of the origin of gangrene through the atherosclerotic lesion may aid in its management. The vascular system is to be considered as a series of tubes or pipes, and the flow characteristics follow the physical laws described a long time ago by Bernouilli—( $E = V \times P$ ). Autopsy specimens sub-

jected to test situations demonstrates that sites of relative decrease in lateral pressure are sites of predilection to atherosclerosis.<sup>3</sup> Also when lateral walls converge, lateral pressure is decreased and velocity is increased. A further development of these concepts allows us to appreciate the intimate mechanisms of the pathologic process. The decreased lateral pressure at the site of predilection causes a suction effect (Figure 1). The intima is elevated, and the endothelium, so affected, tries to repair itself and thus proliferates. The now thickened intima protrudes into the lumen causing increased suction and altered dynamic pressures. Cross section shows a thickened wall, either concentric or more commonly eccentric

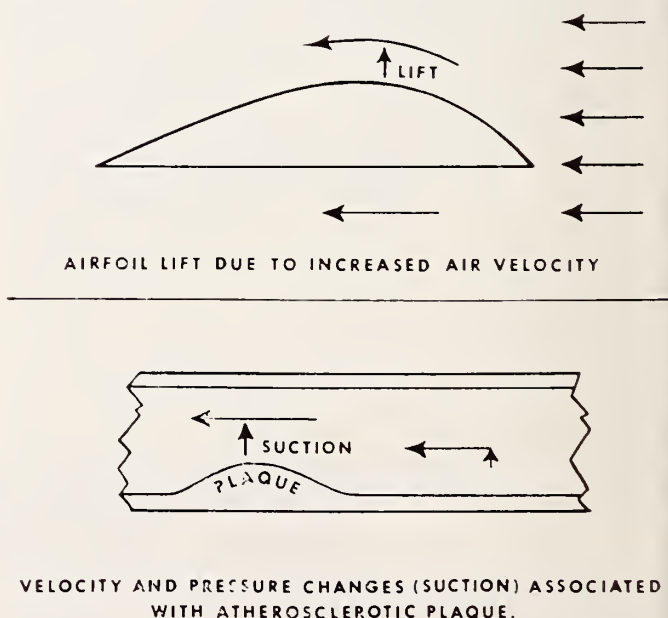


FIGURE 1

Similarity of dynamic factors involving an airfoil and atherosclerotic plaque.

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in pattern. This now becomes the atherosclerotic plaque. The total changes include intimal proliferation, fibroplasia, deposition of collagen, cellular proliferation, lipid deposition, and sometimes calcification. The thickened intima becomes vascularized, and the scene is set for further degradation. The subsequent changes may be sudden or episodic. The rapidly moving blood stream may lift off a fragment of the plaque producing a distal embolus and leave a new, raw surface that acts as a nidus for thrombosis. The continuing suction-like effect may produce intimal hemorrhage which further decreases the effective lumen. The ultimate result of this process is complete occlusion.

Analysis of these studies suggests that certain sites within the circulatory system are most likely to be involved, namely, sites of bifurcation, curvature, branching, converging boundaries, and levels of firm extravascular attachment.<sup>3</sup>

Non-hemodynamic factors of great importance are: heredity, diet, sex, race, endogenous lipid metabolism, drugs, hypertension, tobacco consumption, etc. Hardness or softness of water ingested may also play a role in the formation and acceleration of atherosclerotic lesions.

It has been shown experimentally by Vonruden,<sup>4</sup> that in the presence of decreased flow, distal flow depends upon the maximal degree of stenosis at any one level. If more than one stenosis occurs, the lesser one or ones affects the distal flow a negligible amount. The long stenotic lesion induces no more effect than a short one; not more than five to eight percent further decrease in flow results. In the presence of two stenoses, a) Short with a narrow lumen b) Long with a wide lumen, then the narrow one should be treated if only one can be operated upon at the time. A 50% decrease in lumen produces a 15% decrease in flow, while a 75% decrease in lumen produces a 60% decrease in flow. Symptomatic disease is therefore related to a high degree of stenosis.<sup>4</sup>

Moving over to the smaller vessels, it is significant to know that only six percent of the circulating blood volume is in the capillary bed at any one time. The other 94% is either on its way to or away from this compartment.<sup>5</sup> Since six percent represents 100% of the capillary flow at a specific moment, it is readily seen how a fraction of a per cent would change total flow. Effective peripheral blood volume is influenced by numerous other modalities, including: a) Cardiac Output b) Blood Pressure c) Blood Volume d) Oxygen Saturation e) Hematocrit f) Viscosity g) Peripheral Resistance h) Tissue Metabolism i) Environmental Temperature j) Atmospheric Pressure k) Eschars and Fibrosis, and many other factors.

Learmonth<sup>5</sup> has re-emphasized that the volume of blood flow at a certain point varies with the fourth

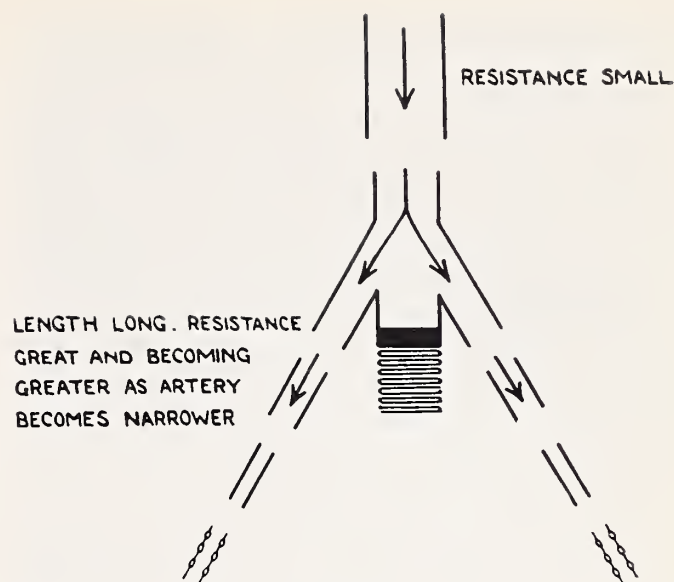


FIGURE 2

Blood reaches capillary circulation only through alternate small arteries with much loss of pressure since these vessels are narrow.

power of the radius of the blood vessel (Figure 2). Landis has shown that pressure at the arterial end of the capillary loop is 32 mm. Hg., and at the venous end it is 12 mm. Hg. There is, therefore a 20 mm. Hg. pressure requirement to drive the blood through the capillary bed. This is the same amount of energy necessary to drive the blood the entire distance from the aorta to the terminal arterial level.

A rarely emphasized point, and one not often appreciated, is a corollary to the above. In the presence of reduced flow to the arteriolar side of the capillary loop, increased pressure on the venous side of this loop further decreases tissue perfusion. Ischemia in this instance is converted to frank gangrene. Thrombophlebitis can and does cause this irreversible type of gangrene in association with arterial insufficiency. Some of the by-pass failures are due to this combination of circulatory phenomena.<sup>6</sup>

### Pathophysiologic Anatomy

Study and analysis of amputation specimens has revealed important information which fits in with the hemodynamic concepts described above. The studies have included x-rays, angiograms, and vessel dissection. Not many years ago, the presence of a gangrenous toe suggested occlusion of a minor vessel, such as, digital, metatarsal, or tarsal artery. Anatomical studies, however, show that with limb gangrene there is always a major vessel completely occluded. (Femoral, popliteal, posterior tibial, anterior tibial, or peroneal.) In 91% of limbs studied, two of these vessels were occluded and commonly at more than one level. In 26% of limbs studied, occlusion over the entire length of the vessel was found.<sup>7</sup>

The posterior tibial vessel was found most often occluded and most thoroughly diseased. Moreover,



GANGRENE OF THE HEEL/Lowenberg

it is also the first branch of the popliteal artery to become occluded. In 46% of the extremities, fresh thrombi were blocking the vessels. Some limbs showed multiple fresh thrombi in the same or different arteries, and almost all were superimposed on atherosclerotic lesions with distal propagation.

Interarterial communications were found throughout the studies and were especially prominent distal to sites of long-standing narrowing. The presence and amount of calcification seen on x-ray had no relationship to the presence or degree of arterial occlusion, or to the extent of the gangrene. This is in contradistinction to what is ordinarily thought to be so. In fact, a large number of the calcified vessels showed no sign of occlusion whatever, the extent of gangrene being poorly correlated with the degree of vascular disease. The latter is undoubtedly related to the rapidity and extent of development of collateral circulation in the areas of arterial narrowing. In some instances, the newly formed channels resemble, in caliber, the vessel occluded. The vasa vasora of the sciatic nerve, for example, play an important role in the total collateral flow of severely ischemic limbs.<sup>6</sup> The largest interarterial communications have been found at the ankle, where they are naturally most needed. In the presence of extensive disease, with occlusion of two of the major leg arteries, the third one is commonly found entirely free of atherosclerosis.

Gangrene has also been found with minimal and localized occlusive disease and with collateral vessels patent. Other factors to be incriminated in such instances are trauma, shock, blood dyscrasias, infection, and nutritional imbalance. The occurrence of thrombosis of the deep venous system, especially prominent in the diabetic, accentuates the vascular embarrassment and in some cases with minimal arterial disease tips the scale in favor of tissue necrosis.

The Patient as a Whole

Patients with gangrene of the heel are more often diabetic than not. In either case, they are people with vascular disease in other vessels. Many of them have had at least one myocardial infarction, evidence of coronary insufficiency, and/or angina pectoris. Cerebral, renal, and ocular vascular disease are common with this group of people. Because of their multiple vessel lesions, these patients are especially poor risks and must be treated in such a manner as to reduce the length of surgical and anesthetic procedures and the number of them. They tolerate multiple procedures poorly. To make matters worse, the older age members of this group, because of diabetic neuropathy and failing vision, adjust to

crutches poorly or never, and at best accept a wheel chair grudgingly, thus the urgency to salvage the failing limb.

Our management of these patients, therefore, must be direct, definitive, and restorative wherever possible. Local infection must be treated actively with topical and parenteral antibiotics as dictated by bacteriological studies. Surgical debridement must be frequent and thorough, but conservative in order not to pare away healthy tissue. Vigorous effort must be made to stimulate and accelerate peripheral arterial flow. This can be done with blocks at the head of the bed, in the absence of swelling. The use of an oscillating bed, with or without swelling is of benefit, but results require prolonged day and night use. All pressure must be removed from the heel; periods of exposure are helpful. Foam or sponge rubber "casts" are helpful at times. They must not be used in such a way as to prevent or obscure view of the heel lesion. Pinch grafts or split-thickness grafts should be used when the lesion is prepared to accept them.

Medical measures should be employed to vigorously correct an alteration of the hemogram. Cardiac arrhythmias are to be treated and congestive failure eliminated. Diabetes should be controlled, and electrolyte and fluid imbalance corrected. Heparin may be employed, especially if venous thrombosis is also present. Dextran is helpful in reducing the tendency of the blood elements to sludge and to decrease blood viscosity. The hyperbaric chamber is being used for this type of case in the few centers where this very expensive equipment is available.

In some areas, amputation continues to be in primary favor for ischemia of the extremity. In the light of present day knowledge and ability to handle these lesions, however, no patient faced with a major amputation should be denied arteriography. It should be kept in mind that following amputation, if this is the only course left, there is a considerable morbidity and mortality. The latter with major amputations approximates ten percent. With gangrene of the foot, amputation rates are the following for a group surveyed in 1961 by Schadt et al.<sup>8</sup>

AMPUTATION RATE				
	Patients	Leg	Toe	Patient %
Uncomplicated .....	209	8	0	3.8
Non-Diabetic .....	314	18	5	7.3
Diabetic .....	48	13	0	27.1

Since the limb mortality with diabetes is so much greater than in non-diabetics, increased effort should be exerted toward salvage. If these people can be returned to an active existence, they seem to prosper as compared with those that must live a bed-to-chair existence. The latter group start downhill and lose

Heparin Sodium, Upjohn Company.  
Dextran 6% Solutions, Abbott Laboratories.



ground rapidly, and consequently succumb to one of the following: cerebrovascular accident, coronary occlusion, auricular fibrillation, congestive heart failure, or pulmonary embolism.

Case History

The following is a typical case history of a patient with heel gangrene. Conservative treatment, including arterial surgery, saved the limb:

J. C., when first examined, was a sixty-seven year-old, white female diabetic patient. Tripping caused her left foot to come out of its shoe, and hit a brick step. This produced local discoloration, and when seen two weeks later by a physician, she had a black great toe and cyanosis of the heel. Treatment by her local medical doctor consisted of vasodilators, penicillin, local ointment, and orinase B.I.D.

Four weeks later, the patient was seen in vascular consultation because of progression of her condition (2-20-64).

Examination, at this time, revealed the patient to have a blood pressure of 210/110. Special attention was given to the examination of the lower extremities, and there was noted black discoloration of the left great toe which extended to the metatarso-phalangeal joint, as well as, gangrene of the medial aspect of the heel (Figure 3). The dorsal aspect of the foot was found to be red and warm. The latter extended up to the junction of the lower and middle thirds of the left leg. Pulses were as follows: Femorals, right and left one plus. Popliteal, right one plus, left zero. Dorsalis pedis, right one plus, left zero. Posterior tibial, zero, zero.

Oscillometry, at the same time, was as follows:

	Right	Left
Thigh .....	4.0	1.0
Calf .....	3.0	Trace
Ankle .....	1.0	0

The patient was admitted to the hospital directly from the office, and the admitting diagnoses were: (1) Diabetes mellitis (2) Arterial occlusive disease, left lower extremity (3) Gangrene of the left great toe and heel, traumatic. Bacteriological studies were done and appropriate antibiotics were instituted, immediately, along with intermittent soaks to institute drainage. When the infection was controlled, arteriography was performed. This demonstrated segmental left femoral arterial stenosis (Figure 4). A left femoral thromboendarterectomy with saphenous roof patch was performed, and amputation of the great toe and metatarsal head (2-28-64).

Following surgery, the oscillometry was repeated, and it was recorded as follows:

	Right	Left
Thigh .....	3.0	2.0
Calf .....	1.0	2.0
Ankle .....	0.5	1.5



FIGURE 3  
J. C. Pre-operative photograph which shows gangrene of the heel, great toe, metatarso-phalangeal joint, and a small lesion of the medial malleolus.

A marked increase in arterial flow in the left leg was thus documented (Figure 5). Two weeks following surgery, the patient was allowed to go home with her lesions healing well. Soaks and antibiotics were continued, but deep infection of the foot reappeared, and on 3-24-64 she was returned to the hospital. On 3-30-64, amputation of the second toe and revision of the first metatarsal amputation was performed. The patient did well following this (Figure 6). Since the ulcer of her heel, previously excised, failed to close completely, on 5-11-64 a split thickness graft was applied to the heel with good take. At the same



FIGURE 4  
J. C. Pre-operative femoral arteriogram shows extensive segmental disease with almost complete occlusion and extensive collateralization.





FIGURE 5

J. C. Post-operative femoral arteriogram which shows reconstruction of the femoral artery with vein patch. Collateral vessels have disappeared.

time, a plantar callus of her right foot was excised. The areas of previous infection and necrosis went on to brisk healing, allowing the patient to return to her role of limited but active housework, including elaborate cooking. Full weight bearing was no problem, and she walked inside and outside the house with minor restriction. A small foam rubber pad was placed within her shoe to take up the space formerly occupied by her first two toes. Two years later, she continues to do well. It is to be noted that immediately after reconstruction of the femoral artery, bleeding was profuse at the site of amputation and debridement, whereas this area two hours previously had been bloodless.

## Surgical Considerations

The surgical approach should be considered after a short, but vigorous, medical regime has been found to fail; that latter will have included debridement. Arteriography (under local anesthesia) must be done, and good pictures of the out-flow tract (Popliteal level or distal) obtained. If at least one artery at this level is seen patent, an autogenous vein bypass graft can be done. If the block is segmental, an endarterectomy may be corrective. Lumbar sympathectomy is still an excellent procedure, if neither of the above can be offered to the patient. It is also valuable prior to, or along with, arterial surgery in



FIGURE 6

J. C. Post-operative photograph, suggesting almost complete healing of all lesions.

order to dilate the collateral bed and add security in the event of failure. Heparin is used in the operating room while the circulation is occluded and not thereafter. The oral anti-coagulants seem to add nothing and need not be used post-operatively. A return of pedal pulses is the best criterion of success. They may appear immediately or in several days. Oscillometry, compared with pre-operative levels, can aid in evaluating operative success. In the event of a successful re-vascularization procedure, there will be a reflex hyperemia and hyperthermia of the extremity. Postoperative arteriography is desirable but should be avoided if its performance would likely jeopardize the limb.

With a success, the necrotic heel will go on to rapid healing with minimal debridement. These surgical maneuvers may be attended with considerable bleeding. Healing will be accelerated by the application of a split-thickness skin graft on a healthy and granulating bed. Ambulation should be encouraged at an early date, and weight bearing permitted soon thereafter.

## Summary

1. The problem of diabetic gangrene of the heel has been reviewed and illustrated. The hemodynamics and pathological aspects have been correlated with the clinical picture.
2. Medical and surgical problems presented by this difficult group of patients have been discussed in depth.
3. A plea is made for arteriography in every case threatened with major amputation.
4. Definitive arterial surgery is offered as the conservative approach, since following amputation, these patients do poorly, rarely learn to walk, and frequently succumb to some other cardiovascular complication.
5. The summary of a patient's record was used to illustrate many aspects of management and final result with this entity.



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## POSTGRADUATE MEDICAL SYMPOSIA TO BE OFFERED AT THE MEDICAL COLLEGE OF GEORGIA

The 1966-67 Georgia Circuit Course presents six postgraduate symposia for physicians at afternoon and evening sessions, one day each month, November through May. The programs are offered at six cities in Georgia.

Emphasis will be upon the differential diagnosis and management of conditions which commonly present to clinical physicians. The program contains didactic lectures and panel discussions, and opportunity is provided for questions and comments from enrollees. Each program begins at 2:00 p.m. and contains four and one-half hours of instruction.

The course is planned for both generalists and specialists. The course is acceptable for twenty-seven (27) hours of credit by the American Academy of General Practice.

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This five-day course will include metabolic disorders, infectious diseases, radiology, pulmonary disease, hematology, pediatrics, urology, and obstetrics and gynecology.

### Advanced Course in Psychosomatic Medicine October 5-December 21, 1966

(Twelve weekly sessions on successive Wednesday evenings)

Enrollment for this course is limited to practicing physicians who have previously attended either an introductory course in Psychosomatic Medicine (at the Medical College of Georgia or elsewhere) or the Psychiatry in Clinical Practice course on August 24-25, 1966.

### Pediatrics December 8-9, 1966

This course will cover multiple topics of importance in the medical evaluation and care of children.

### FOR TECHNICIANS AND CLINICAL PATHOLOGISTS

### Medical Technology Seminar and Workshop January 27-28, 1967

The Seminar will provide opportunity to review basic concepts and proper control measures to assure reliability.

The Workshop is designed for the participants to gain firsthand experience in the evaluation of techniques, to discuss inherent problems of test systems, and relate these to the theoretical aspects discussed in the Seminar.

### Acquired Valvular and Congenital Heart Diseases March 1-3, 1967

The etiologies, diagnosis, and management (medical and surgical) of these conditions will be discussed. Since individualized instruction will be given in the bedside diagnosis of selected cardiac conditions, the enrollment for this course will be limited.

### Pediatric, Adolescent and Geriatric Gynecology March 14-15, 1967

During the first day infections and trauma in children as well as endocrinopathies will be discussed. The second day of the course will be related to the problems of the climacteric including the use and abuse of hormone therapy.

### Rheumatic Diseases March 21-22, 1967

This course will cover the broad spectrum of rheumatic diseases involving joints and multiple other organ systems and will include the connective tissue (collagen) diseases.

### The Adrenals in Health and Disease April 20-21, 1967

The clinical physiology and pathophysiology of these glands and related therapeutic considerations will be presented in this seminar.

### Registration

In order to know the attendance that may be expected, advance registration is requested.

### Fee

The advancement payment fee for the entire course of six programs is \$40.00. The fee for a single program is \$10.00. Please make checks payable to the Medical College of Georgia.



# COMPETITIVE SPORTS FOR BOYS UNDER FIFTEEN BENEFICIAL OR HARMFUL?

Fred L. Allman, Jr., M.D., *Atlanta*

- If properly supervised, the end results will be beneficial for the child, and the risks to his physical and mental well-being will be negligible.

FEW SUBJECTS INCITE more controversy among physicians than the question of competitive and body contact sports for boys under the age of 15. A recent national poll of physicians by *Medical Tribune* indicated that 43.5% of physicians polled expressed unqualified opposition to body contact sports, while 40.5% felt that such activities were not too hazardous if properly supervised.<sup>1</sup>

## Too High a Price

The physicians that oppose contact sports seem to be mainly in agreement with Dr. Carl V. Lendgren who has stated, "These are the tender years when muscles lack the fibrous toughness needed for protection. Ribs and skull bones are too fragile and even the skin is tender and easily torn. Judgement, as well as body, is immature. Broken wrists, legs, torn ears, lacerated faces in these children represent too high a price for the fun or training they may receive."<sup>2</sup>

Proponents for contact sports generally agree that the benefits of competition outweigh the hazard of injury if the program is properly supervised.<sup>2</sup>

In order to fully evaluate the benefits of competitive sports, a better understanding of the hazards involved in such activities must be undertaken. These usually fall into two categories, physical and emotional.

### I. Physical

- A. Acute injuries to musculoskeletal system, especially epiphyseal injuries.
- B. Late effects of microtrauma.
- C. Specialization too early.

#### A. Acute Injuries to the Musculoskeletal System

Much has been written and even more said about the potential danger of permanent impairment to

growth because of epiphyseal injuries. Many physicians agree with Dr. Lendgren and feel that these are truly "the tender years." Certainly there can be no question that our youngsters who compete in contact sports do on occasion sustain injuries, and these are sometimes serious or even fatal. In spite of the strong feelings that many physicians have regarding the potential harm of epiphyseal injuries, very few statistical studies have been reported regarding these injuries. As a result of this information void, an attempt has been made over the past few years to obtain data from areas where contact sports are allowed during this age span.

Drs. Larson and McMahan recently reported on a review of 1,338 consecutive athletic injuries.<sup>3</sup> In their survey 20% of the injuries occurred in the age group below 15. Only 6% of those injuries were epiphyseal injuries. The youngsters in that age group comprised 60% of the school population. Also of importance, their report indicated that 40% of the injuries occurred in the 15-18 year age group which comprised only 15% of the total school population. (Therefore the high school students appeared to be the most vulnerable to athletic injury.) The conclusion reached by these authors was that although epiphyseal injuries did occasionally occur, they did not necessarily mean deformity, and that the benefits derived by children participating in athletics outweighed such an indefinite potential.

The late Frank Barnes, surgeon in Smithfield, North Carolina, gathered data from several communities where midget football was played. A review of injury records revealed that injuries of any type were unusual and fractures were extremely rare. (See Table I.)

Gallagher reported on records of 650 students at Phillips Academy over a seven-year period, ages

TABLE I  
MIDGET TACKLE FOOTBALL

Kingston, N.C.
400 players, 1 fractured wrist
Morehead City, N.C.
260 players, 59 games, 7 injuries (3 fractures)
Smithfield, N.C.
110 players, 3 seasons, 0 fractures
Raleigh, N.C.
224 players, 1 dislocated shoulder
Elizabeth City, N.C.
100 players, 12 seasons, 9 fractures
Durham, N.C.
350 players, 1 fractured toe

13-18 and stated that there were "few epiphyseal injuries."<sup>4</sup>

Seventeen Dallas, Texas, junior high schools representing 1,253 football participants reported only a small percentage representing epiphyseal injuries.<sup>5</sup>

The injury incidence of 16,500 Junior High Football players in New York was 11.2% with no mention being made of epiphyseal injuries representing a problem.<sup>6</sup> In 1957 junior high schools in New York representing approximately 2,000 participants in tackle football reported two or less injuries in 21 schools and five or less injuries in 38 schools.<sup>7</sup>

Yearly records have been kept on participants in the YMCA Tackle Football Program in Atlanta.<sup>8</sup> These represent the Y-Guys who are in the second and third grade, and the Gray-Y representing grades four through seven. There are 1,450 participants, and prerequisites for competition are minimal, being only tooth protectors, suspension helmet and soft shoes with rubber cleats. Yet, total injuries in 1965 were 31—there being only six fractures (four forearm, one metacarpal and one finger), hardly enough to classify the program as a health hazard. Certainly, during this same ten-week period at least six youngsters out of nearly 1,500 non-participants would have fallen from a tree, or a bicycle, or been struck by an automobile, producing a much more serious injury. Some might even have had time to engage in a mischievous act or embarked upon a career in crime.

Although rare, fatalities do occur as the result of contact sports. However, one of the largest tackle football programs for youngsters, The Pop Warner Program, has had over one million participants in the past 34 years without a fatality, a record that speaks well for the leadership and organization within the program. "What constitutes undue risk from participation in sports remains intuitive. Understanding what goes into a yardstick of risk plus a respect for the limited utility of fatality-risk figures are a sound combine for rebuttal of intemperate conclusions."<sup>9</sup>

#### B. Late Effects of Microtrauma

Too often history records the disaster which in earlier years had been considered prudent. Little did the luminous watch dial painters realize that in 30

years most of them would be dead of bone cancer because of the effects of radium. Nor even now do many fully realize the harmful effects accumulated over the years by the habitual use of cigarettes.

Although sports activities have been present since the beginning of man, they have not had the organization and the altered techniques of today. (The "wear and tear" on joints, especially the neck and knee of football players, and the elbow and shoulder of baseball pitchers may produce changes which do not become apparent for many years.) It becomes necessary therefore to be on the lookout for techniques that may be especially harmful and to make certain that these are eliminated from the athletic program. Probably the greatest offender of this generation of football players is the procedure known as "spearing." This is blocking or tackling with the head—the main purpose being to inflict pain or discomfort to the opponent by using the front or top of the helmet to strike the player in the sternum or back. This not only may produce serious acute injury, but is most certain to produce degenerative changes in the cervical spine if continued over a sufficiently long period. Coaches in the professional and college ranks argue that their boys are prepared for this activity by special exercise programs that help to strengthen the cervical spine. Serious doubt must be given that any spine could be prepared for such activity when continued over a period of years. More important, however, is the fact that the high schools and midget programs frequently mimic the colleges and the pros—and therefore they also teach spearing. Most youngsters cannot possibly have adequate musculature to protect them properly during this type of activity. Even if acute injury is avoided, chronic changes are sure to occur if the practice is continued throughout the years of football competition.

Organized leagues in baseball are now available for youngsters beginning at age six. If a boy is good he will usually go from one league to another, play for his school in the spring and the league in the summer. (Many young pitchers throw curve balls, sliders and fast balls, but few are taught the importance of warming up slowly and cooling off slowly. Prolonged pitching over many years without adequate conditioning, and pre and post performance care of the arm, will surely result in degenerative changes about the elbow and shoulder.) Adams,<sup>10</sup> Bennett,<sup>11</sup> Middleman,<sup>12</sup> Meyer and Dively<sup>13</sup> have noted these shoulder and elbow changes, and called attention to the importance of proper recognition and care.

#### C. Specialization Too Early

Although there are certain skills that are specific for each sport there are other factors which are basic for the hard core of sports fitness and there are gen-



erally speaking the same for nearly all sports. Basic fitness work should always include the practice of skills of many sports, even though they seem unrelated to one's special event. This is especially important during the early years of training. Other sports are basic training in skill learning.<sup>14</sup>

"A candidate for football should be a year-round athlete. This does not mean that an aspiring young halfback should devote his attention to football *per se* during the off season. Nor does it mean that he must participate in competitive sports all year long. Rather, it means that every athletic minded boy should be enjoying a high level of physical readiness for sports regardless of the season. The payoff is more injury free time to spend on refinement of skills when competitive practices begin—especially for a contact sport like football."<sup>15</sup> (A comment by the National Federation of State High School Athletic Associations and The Committee On The Medical Aspects of Sports of The American Medical Association.)

The recent success of the Soviet athletes in the Olympics has been attributed in part to the fact that they have learned that specialized athletic performance rises highest when founded upon a broad base of multisports training. Youngsters in Russia are encouraged to engage in many sports.

The development of motor skills depends partially upon maturation. It therefore becomes necessary to utilize the potentiality which is associated with changes in the function ability of the individual. If this potentiality is neglected then the same high level of performance that might have been attained will never be reached.

Skill training concentrates on teaching the correct technique for the individual based on his or her own natural movement. Studies at the Laboratory of Applied Physiology at Southern Illinois University have demonstrated that there may be at least three distinct patterns of throwing. Each pattern can be highly successful within itself; however, the methods of teaching throwing attempt to have a boy throw in a standard pattern which means changing his basic pattern.<sup>16</sup>

Much has been learned in recent years by observing champions during top performance competition. While a study of these champion athletes has helped others to improve performance, these techniques have for the most part evolved over a number of years. It therefore may be very incorrect to try and teach this same technique, which has been acquired by one athlete over a number of years, to the beginning athlete who has not yet reached the same level of maturity.

In order to better organize and formulate athletic activities for the preadolescent it is necessary to have a basic understanding of the emotional, as well as the physical profile of these youngsters. It has been said that all children are alike in one respect. They are all different.<sup>17</sup> This difference is especially notable in their wide variation of maturity levels and in their fluctuating mood. They have much enthusiasm and energy, but are probably not as aggressive or as highly competitive as are adolescents.<sup>18</sup>

The characteristic which is most important of this age, however, is the desire of acceptance and recognition with the peer group. Being an individual star is not as important to the participant as simply being a part of the team, and if paternal interference is limited, and too much emphasis isn't placed on winning, thus avoiding a high pressure, demanding atmosphere, then physical, intellectual and emotional development will be aided by sports participation.

Parents should set proper examples of sportsmanship for their youngsters by not being too critical of the officials, second-guessing the coach, booing the opponents and especially not deriding their own children for making an error or losing.

A coach once said, "Show me an athlete who doesn't mind losing and I will show you a loser." Dr. Maxwell Maltz feels that we all have a "self image."<sup>19</sup> Some people have failure images while others have successful images. Those with failure images see failure as being final, while those with winning images see failure only as another step which has gained them experience that will help to achieve ultimate success. Too many failures, especially at a young age, tend to lower an athlete's level of aspiration. Reward usually has a greater motivation effect in improving performance than punishment, although in some cases punishment produces the greater effect.

Parents and coaches must be careful not to encourage failure or mediocrity, and at the same time not to emphasize winning at any price.

Emphasis on winning should not be so great that an individual is denied participation because of the likelihood that he will make an error.

The coach should not only consider performance, but also desire, effort and the need of the individual for physical and emotional development.

Dr. R. A. McGuigan has noted the wide variance between children of a given age and also has observed that those whose coordination is best will learn a specific athletic skill more quickly than others.<sup>2</sup> He feels that since this combination of coordination and skill does not reach an adequate peak by the age of 12 years, it would seem irrational to say that children of this age or below should take part in body contact athletics. His suggestion that these years



could best be used to improve and develop fundamental body control and specific skills is well founded. However, the disparity of coordination and skill between the "gifted" and "non-gifted" will become greater as the youngster grows older, and to deny the "non-gifted" the opportunity of team participation in contact sports while he is a preadolescent may mean denial forever.

It is also important to realize that interest in gymnastics, track and even swimming is not nearly as great during this age span as is the interest in football. In most cases the father is anxious for his son to play football and encourages him to do so by giving him a complete (but not very safe) football outfit by the age of two or three. In many areas of the country leadership is also lacking in most sports other than football.

If no program is provided most of these youngsters will congregate in the street or vacant lot without any supervision, or else will sit in front of the TV for several hours, learning to spend their leisure time like mom and dad.

Perhaps someday soon with proper education of mom and dad, and with the addition of properly trained coaches, these years can be devoted to activities designed to develop and improve fundamental body control and specific skills.

### **Guidelines for Athletic Programs for Preadolescents That Are Consistent With Emotional and Physical Development**

*I. General:* Competition should be conducted in an interesting and equitable manner and kept in the proper perspective at all times. (It is easy to lose perspective and allow the things that are most important to become the victim of the things that are least important.) Sportsmanship should always be promoted and a certain dedication to the sport should be expected of the participant. Without this dedication, or unconditional commitment, there will be no discipline. The sport should be supervised by trained and qualified leaders and available to all interested children, not only the few athletically skilled.

*II. Preseason Physical Examination:* Before undertaking strenuous physical activity in any sport, a careful physical examination and history are a must. Any physical impairment must be evaluated, and correctable physical abnormalities treated. Those who are found to be incapable of physical exertion should be eliminated. (To these individuals some other form of activity compatible with their physical capabilities should be made available.)

*III. Good Coaching:* The proper teaching of basic skills and techniques are important and physical fitness should be a must. Instruction should not be too sophisticated for fear of producing frustrations and disappointment. Prudent practice and game proce-

dures must be utilized and strategy and skill are always taught within the rules. The vision of the coach must go beyond developing skills and winning games.

*IV. Protective Equipment:* Designed to diffuse the energy imparted by a blow over as wide an area as possible. The equipment must be constructed properly, fitted to each individual, and worn properly. In football and other contact sports tooth protectors should be mandatory.

*V. Good Playing Facility:* Provide adequate, well-constructed, safe equipment with unobstructed play areas. Ground should be smooth, free of rocks and glass, and with suitable sod.

*VI. Good Officiating:* The various rules provide for competition to be conducted in an interesting and equitable manner, and at the same time specifically prohibit unnecessary roughness, unfair tactics and unsportsmanlike conduct. It is important that the sport be played in accordance with the letter and the spirit of the rules. The action of the players must be in conformity with the rules and the game officials must accept the responsibility for enforcing rules promptly and with consistency.

*VII. Equitable Competition:* For safety and fairness, competition should be between individuals of similar development, both physical and emotional. During this age span there may be great variations in the preadolescent growth spurt and since size and strength are important determinants of failure or success in athletics, these factors must be considered in forming teams.

*VIII. Proper Medical Supervision:* Good sound health principles should be exercised in taking care of equipment, dressing rooms and playing fields, as well as in care of the athlete. Preventative measures must be employed and immediate proper treatment instituted whenever necessary. Injury may be the only signal of a player's physical or mental unreadiness for competition. Records of injuries should be maintained and reviewed.

*IX. Paternal Guidance:* Most children want to please their parents and many will work harder for a mother or father than for anyone else. This does not mean that the parent should become a coach, but rather they should cooperate with the coach. Parents should give encouragement to talents that are shown by their children, whether in sports, the arts or in the classroom. Self-confidence and reassurance begin at home. Help the coach by guarding the health needs of the child, watch his diet, be sure adequate rest is obtained and see that he obeys the rules and regulations established by the coach. Be sure they arrive at practice and to the game on time, but most of all, be certain to set the proper example of sportsmanship. The child who overhears parents being critical of officials, coaches or other players, often becomes a poor sport too.



## Conclusion

While there are certain hazards involved in competitive contact sports for youngsters below 15, there are certain very definite benefits. The value of sheer physical exercise demanded by participation in these sports cannot be denied, nor can the benefit of competition. Competition is a part of life, and there is no better way to learn to compete than through well-controlled sports activities.

Social benefits include new friendships, the feeling of belonging and being part of a team, enlightened and interested tools to mold good citizenship and acceptable behavior, and emotional stability.

The emotional profile of athletes reveals them to have a greater achievement orientation, a greater willingness to pay the physical and emotional price for success, to be more in touch with the reality demands of life, to be more open and trusting and to be warmer and more socially conforming.<sup>20</sup>

Moral and spiritual values include a stronger character, and a greater sense of loyalty and self denial. The late Herbert Hoover once said, "Next to religion, sports are the greatest developer of morals."

Parents, coaches and physicians must evaluate each sports program with a larger vision than just winning games or developing skills. As A. A. Esslinger of the University of Oregon has stated, "The standing in the league at the end of the season and the scores are soon forgotten. The really important thing is what happens to the boy in the process."

Dr. Thomas E. Shaffer<sup>21</sup> has stated that when athletic program supervisors rigidly observe the standards set forth by medical and educational authorities, the end result will be good for the child and risks

to his physical and mental well being will be negligible.

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## DUKE ESTABLISHES A SOUTHEASTERN REGIONAL CENTER FOR TROPHOBLASTIC NEOPLASMS

The Department of Obstetrics and Gynecology, Duke University Medical Center, announces the establishment of the *Southeastern Regional Center for Trophoblastic Neoplasms*. This Center is sponsored by a Health Service Project Grant Award from the Department of Health, Education and Welfare, Division of Chronic Diseases.

This project in Cancer Control is established for the purpose of providing urinary gonadotropin assays and consultative assistance to physicians to aid in evaluation

of patients who have or are suspected of having abnormalities in trophoblastic tissue growth.

Beginning September 30, 1966, physicians desiring gonadotropin assays for patients with placental abnormalities as molar degeneration, hydatidiform mole, syncytial endometritis, chorio-adenoma destruens and choriocarcinoma may call or write the Center at Duke University Medical Center, Durham, North Carolina (Area Code 919, 684-8111).

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# SALVAGE OF THE SEVERELY INJURED HAND

Grady S. Clinkscales, Jr., M.D., *Atlanta*

- All aspects of treatment of the acutely injured hand are discussed.

THERE ARE SIX BASIC STEPS in the preservation of function of a hand which has been subjected to severe trauma. First, the extent of the injury must be determined and the details of the damage recorded. Second, damaged tissue must be debrided. Third, the initial treatment is carried out. This is followed by the fourth, immobilization during the early healing process; then fifth, a rehabilitative stage. The sixth and last step can be broadly considered under reconstructive procedures—after which the complete cycle of re-evaluation, surgery, immobilization, rehabilitation, and further reconstruction is repeated until maximum function has been achieved.

## Extent of Injury

In determining the amount of damage one must remember that there are five tissues: Skin and subcutaneous tissue, blood vessels, nerves, tendons, and bone. Any one or combination of them may be involved. In a crushing injury, e.g. from a heavy object, swelling and edema of soft tissues occur rapidly and are followed by thrombosis of small blood vessels and subsequent fibrosis and stiffness. In explosion injuries the wounds may be relatively clean, but damage to the soft tissue is usually not fully appreciated initially. The percussion produces induration of all tissues and fractures as well. The delineation of viable tissue is even more difficult in the crushing associated with roller injuries. Considerable contamination with grease, paint, ink, or cloth adds to the difficulty. The skin may be avulsed—literally peeled—from the surface of the hand and while the initial damage may not appear extensive, the blood supply to skin is severely compromised. This is particularly true of skin flaps which remain attached distally.

Debridement of devitalized tissue is a well estab-

lished surgical principle. Irrigation of foreign material and blood clots goes hand-in-hand with debridement. Degloved skin must be excised. The debridement of other soft tissues and bone must be meticulous, preserving in every instance all that is possible.

## Initial Treatment

This third stage involves the initial care of fractures, dislocations, the repair of neurovascular and tendon involvement, and the replacement of skin coverage. If a fracture involves only the distal phalanges, splinting alone is usually sufficient. In more severe injuries, however, there are frequently multiple compound and comminuted fractures which make anatomical reduction difficult. Because of the compactness of structures and the important gliding surfaces adjacent to these small bones, anatomical reduction is imperative and can be greatly facilitated by splinting internally with Kirschner wires. These wires should be positioned so that they do not impale the neurovascular bundles or the tendons. One Kirschner wire may afford sufficient stability, but in grossly unstable fractures a second wire may be necessary. One should be wary of crossing these Kirschner wires as this tends to distract the fragments and thereby delays healing. Wires should be cut beneath the level of the skin to minimize the possibility of a pin tract infection. If the wound is already compound, these fractures may be reduced open. Otherwise, they may be reduced by manipulation and transfixing them with a blindly-passed wire.

## Dislocations

Dislocations at the distal and middle joints of the fingers are much more common than at the proximal joint. Reduction is usually easily accomplished by merely reversing the direction of the deforming force. Occasionally, however, the fibrocartilaginous plate is pulled from its attachment on the volar aspect of

the proximal phalanx and the head of this phalanx buttonholes through the capsule, making reduction more difficult. Dislocations of the carpal bones, particularly at the base of the thumb, may be missed. These bones are embedded in bulky muscle on the radial aspect of the hand and even in the face of a dislocation or fracture-dislocation, gross deformity may go unnoticed. If such a dislocation heals in malposition, open reduction is usually inevitable.

### Tendon Reactions

Extensor tendons glide across the dorsum of the phalanges and metacarpals through relatively loose tissue. In clean lacerations the extensor tendons can usually be repaired primarily. The arrangement of the flexor tendons on the volar aspect of the hand is much more complex, however. In the palm the sublimis are volar to the profundus tendons and a superficial laceration will sever the sublimis alone while a deeper laceration will divide both the sublimis and profundus tendons. At the level of the proximal phalanx the sublimis tendon bifurcates and each of the two slips rotate laterally and dorsally so that they then lie deep to the profundus tendon before reaching their insertion across the volar plate and into the base of the middle phalanx. A shallow laceration at this level then may divide only the profundus tendon while a deeper one involves both.

The profundus tendon alone extends past the middle phalanx to insert at the base of the distal phalanx. Therefore, lacerations here would divide only this tendon. Between the volar carpal ligament and the distal flexor crease of the palm, a primary repair of both sublimis and profundus tendons can be carried out. Between the distal flexor crease of the palm and the middle joint of the finger, both tendons are snugly encased in a firm fibrous tunnel. Each of these two tendons has a different length of excursion and therefore, they glide not only through the pulley system but against each other as well. If both the sublimis and profundus tendons are repaired in this area of "no man's land," healing takes place by scar formation and adherence of one to the other with loss of function. Therefore, the sublimis tendon must be resected and the profundus tendon repaired. Both the timing and the type of repair is controversial but in general a primary closure of the wound, followed later by a tendon graft for the profundus, is the more rewarding.

### The Nerves

When a laceration on the volar or lateral aspect of a finger produces brisk arterial bleeding, a digital nerve is assumed to be severed until proven otherwise, since this nerve lies superficial to its accompanying vessel. Under optimum conditions, i.e., a clean sharp laceration seen within a few hours of

injury and with the necessary equipment and assistance available, a primary neurorrhaphy offers the best results. Repair of volar digital vessels is usually impractical because of their size and these are usually ligated at the time of the nerve repair.

### Skin and Tissues

If the damaged skin and subcutaneous tissue is contaminated only along the border of the wound, the edges alone may be freshened and reapproximated. One should attempt whenever possible to obtain primary closure of the wound even if it means delaying other procedures for tendon repairs, neurorrhaphies, or reconstructive bone procedures. If skin has been degloved from a portion of the hand, this may be replaced with a split-thickness skin graft which offers the greatest chance for skin survival. In a clean wound, a full-thickness skin graft may be applied primarily. For skin loss on the palm, if deep enough to expose the neurovascular structures and tendons, a primary abdominal pedicle flap may be necessary.

If the injury is a relatively simple one, i.e., from a laceration, the decision as far as the type of repair is relatively easy. When the injury has been so severe as to completely mangle all tissues, the decision not to salvage any portion of this limb is equally simple and one has no recourse but to amputate at the most desirable level. There is a wide gray zone, however, in which the decision of "how much to save" is more difficult. It is axiomatic, however, that if three of the five tissues in any combination can be satisfactorily preserved, one should attempt to salvage that portion.

### Immobilization

The fourth step in the management of an acutely injured hand is immobilization. Swelling and edema are natural consequences of tissue injury. This is best combated by bulky, snugly applied dressing and by elevation. Immobilization should satisfactorily put to rest those forces which act on the injured part. This includes not only the intrinsic forces whose muscles originate and insert within the hand, but the extrinsic forces as well. This, of course, involves muscles and tendons arising in the forearm. Immobilization should in most instances then include the wrist in the position of function—slightly hyperextended with the fingers slightly flexed.

### Rehabilitation

Now the fifth stage—rehabilitation. Prolonged immobilization of the small joints of the wrist and hand promotes stiffening that is quite difficult to overcome. Whenever possible, mobilization of all unaffected areas should commence immediately and of the affected areas as soon as satisfactory healing permits. For most injuries, including fractures, such



## INJURED HAND/Clinkscates

mobilization can be instituted as early as three to four weeks in spite of the radiographic appearance at this time. Sufficient clinical stability will permit guarded active exercises. No less important than the initial surgical repair is the surgeon's responsibility to emphasize to the patient the necessity for frequently exercising the affected part, by gentle passive stretching exercises or by using rubber bands, blocks of wood, bars of soap appropriately placed in the palm of the hand. Dynamic splints can be even more effective in the severely stiffened joints.

### Reconstruction

Reconstruction encompasses virtually an entire field in itself. This includes delayed repair of nerves and tendons, releasing flexion contractures due to adherence of tendons, or contracted fibrous tissue of the joint capsule and ligaments, and releasing skin contractures. It also includes bone grafting procedures for non-union, osteotomies for mal-union, and following each of these procedures the cycle of

immobilization, mobilization, and rehabilitation is repeated.

### Summary

In the management of the acutely injured hand, then, as soon as the injury has been assessed, such definitive care as the conditions warrant is carried out. This depends upon the extent and type of tissue damage, amount of contamination, and the time elapsed since injury. Fractures should be reduced anatomically. Internal fixation facilitates repair of adjacent damaged tissue. Extensor tendons and volar digital nerves, under ideal conditions, can many times be repaired primarily. Flexor tendon injuries usually require a secondary repair. The skin wound should be closed primarily and skin grafts added when necessary. Elevation, adequate immobilization in the position of function, and bulky dressings reduce edema. Early motion of small joints hastens recovery. Meticulous attention to these details will produce maximum return of function which will be rewarding both to you and to the patient.

*478 Peachtree Street, N.E.*

## AMA PROPOSES RURAL EMERGENCY CARE PLAN

The American Medical Association's Council on Rural Health has offered a five-point program for improving emergency medical care in rural areas.

The program is the first step in a larger AMA project to insure excellence of emergency care nationwide.

As outlined by the council, the program in particular stresses wider first aid training for rural Americans and swifter handling of emergency victims.

### Rural Injuries Higher

Bond L. Bible, Ph.D., secretary of the council, pointed out that a study of traffic fatalities indicates that "people injured in rural counties were almost four times as likely to die of their injuries as those injured in urban counties, despite the occurrence of less severe accidents and more survivable injuries."

"The higher case fatality ratio in rural areas seems to be related to the inability to provide adequate first aid procedures and to get the person to a hospital within a reasonable period of time," Dr. Bible said.

"In addition to motorists, emergency medical transportation and first aid arrangements are also highly important to farm families," he continued. "The National Safety Council reports that 740,000 disabling injuries occurred on farms during 1965 and that farming ranks third behind mining and construction jobs in accidental death rates."

The rural health council's program, approved by the AMA Board of Trustees, urges that:

1. Rural communities coordinate their efforts with adjacent towns or urban centers in analyzing existing patterns of response to medical emergencies.

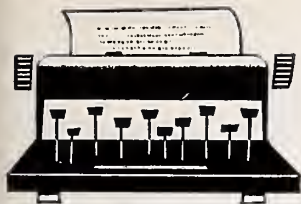
2. Rural and urban communities institute a medical service area program for emergency medical transportation facilities and health personnel.

3. Rural and urban communities where possible, adopt the model ambulance ordinance to give the public a greater voice in the quality of ambulance care. (The ordinance proposes standards for ambulance equipment, personnel and operation, liability insurance requirements, maintenance of records, duties of regulatory agencies, and penalties to be imposed if the ordinance is disobeyed.)

4. Rural and urban communities provide a program of advanced Red Cross first aid instruction for the non-medical people most frequently called in rural emergencies—especially police, sheriffs, and ambulance crews.

5. Rural and urban communities develop a continuing campaign directed toward first aid instruction for rural families and particularly young people through the schools, youth organizations, and other educational channels.

Assisting in organizing and implementing the program are the American Red Cross, Federal Extension Service, Department of Health, Education and Welfare, National Education Association, the National Grange and American Farm Bureau Federation.



## GOODPASTURE'S SYNDROME

**I**N REPORTING on the visceral complications of erythema exudativum multiforme, William Osler, in 1895, mentioned the frequency of nephritis in this disorder. He also noted hemoptysis in two of his patients that had nephritis but in neither was massive or even moderate pulmonary hemorrhage a prominent symptom.<sup>1</sup> In 1919, Ernest W. Goodpasture described a hemorrhagic pneumonia associated with what was thought to be influenza.<sup>2</sup> In this paper Goodpasture presented two cases, one of which was quite typical of influenza but the other was quite unusual. This latter case was a young man who had a typical attack of influenza from which he finally recovered. However, his cough persisted, he became weak over a few days and he experienced weight loss, all of which necessitated his being readmitted to the hospital where he was found to have a cough productive of bloody sputum, chest pain, anemia, and signs of bronchopneumonia. The pneumonia became massive with the production of much bloody sputum, fever, and dyspnea leading to death three days later. There was albumin in his urine but hematuria was not mentioned.

### Persistent Virus

At necropsy the lungs showed a tremendous amount of blood in the alveolar spaces with foci of necrotic alveolar walls. Cultures showed no bacterial pathogens. The kidneys showed a glomerulonephropathy with fibrinous exudate in Bowman's capsule and cellular proliferation of the glomerular tufts; some urinary tubules were filled with erythrocytes. Goodpasture mentioned that the lesions in the kidney might be evidence that this particular case was not simply an influenzal infection, but he also suggested that it was not inconceivable that the virus might have persisted in the body for six weeks resulting in the lesions found in this young man.

### Association Known

The association of a hemorrhagic lung disorder with glomerulonephritis has been known for many years. Since 1919, about 100 cases have been reported that have exhibited a rather consistent type of hemorrhagic pneumonia with an associated glo-

merulitis. Clinically, they have had a similar course and thus have offered evidence that this disease process is distinct enough to represent a definite clinico-pathologic entity. The occurrence of a hemorrhagic type of pneumonia and nephritis with a rapidly fulminating clinical course with its typical signs and symptoms was termed Goodpasture's syndrome by Stanton and Tange<sup>3</sup> in 1958, but Rusby and Wilson,<sup>4</sup> in reporting their cases in 1959, preferred the term "lung purpura with nephritis." The clinical features of Goodpasture's syndrome were well documented by Benoit in 1964, after reporting nine cases at the U. S. Naval Hospital in Oakland, California.<sup>5</sup> About 40 cases were reviewed and the results were tabulated.

Goodpasture's syndrome does not apply to cases of nephritis complicated by hemoptysis due to recognized pulmonary complications of renal disease, such as pulmonary embolism and left ventricular failure, or patients with pulmonary hemorrhage that might be ascribed to the hemorrhagic tendency of the uremic state. Nor is it usual to include under this term patients with an obvious diffuse vasculitis affecting other organs in addition to the lungs and kidneys.

The world-wide distribution of this syndrome is well known, being reported in Australia, England, Germany, Ireland, New Zealand, Norway, and the United States. Predominately it affects young caucasian males, the median age being 21 years. Females are rarely affected.

### Characteristic Symptoms

The symptoms are rather characteristic with hemoptysis almost invariably being present initially. Hemoptysis may vary from blood streaked sputum to massive pulmonary hemorrhage, and it has the tendency to occur in bouts. Exertional dyspnea is often present and is usually more prominent with the more severe episodes of hemoptysis. These patients frequently complain of weakness and easy fatigability and not uncommonly give a history of a prior upper respiratory tract infection of a non-specific viral nature. Occasionally, chills, fever, and sweats are



encountered but usually these are associated with acute pulmonary hemorrhage. Weight loss may occur as it did in the patient described by Goodpasture. Substernal chest pain may be present and is frequently aggravated by cough. Gross hematuria and rarely hematemesis have been reported. A migratory type of polyarthritis<sup>7</sup> occasionally is observed that sometimes precedes respiratory and renal symptoms by a long interval.

### **Clinical Signs**

The clinical signs found in Goodpasture's syndrome are quite constant, the most common being an extreme pallor, most prominent in those patients with marked anemia. Rhonchi are usually heard in the lower lobes. Initially the blood pressure is normal but becomes elevated with terminal renal failure. Edema is initially absent but present terminally. Bloom<sup>6</sup> reported five cases in 1965 in which the nephrotic syndrome was present with massive edema. In Bloom's cases a high incidence of venous thrombosis was encountered which was not noted in other series. Occasionally ecchymotic, petechial, or maculopapular skin rashes may be noted.

Anemia was universally present early in the course of the disease with the usual hemoglobin value about 8.0 grams per cent. The lowest concentrations are associated with more severe pulmonary hemorrhage. Radioactive iron studies on one patient revealed that 1,850 milliliters of blood were sequestered into the lungs during a 37 day period of observation. The anemia is normochromic, normocytic initially with a later change to hypochromic and microcytic. Reticulocytosis has been present in a few cases but normal counts are generally noted. Leukocyte counts range from 5,000 to 25,000 with polymorphonuclear leukocytes predominantly. Coagulation studies including bleeding, clotting, and prothrombin times have been done along with platelet counts and tourniquet tests, all of which are usually reported within normal limits. However, in one of the patients in Bloom's series a severe coagulation defect was found and a circulating anticoagulant was suspected. The few patients that have had erythrocyte survival studies were found to have decreased survival times. Tests for hemolysis including Coombs and fragility tests along with cold agglutinin studies have been normal. Jaundice is rarely present, and bone marrow examinations for the most part have been normal.

Azotemia is noted late in all patients. Invariably proteinuria is found, varying from six to 12 grams per day. Microscopic hematuria is noted in a high percentage with pyuria less common. In slightly more than half the cases, granular casts are found, but red

cell casts, oval fat bodies, or maltese crosses seldom are noted.

Electrolytes are normal except terminally when hyperkalemia may supervene. Liver function studies including cholesterols are not remarkable. Total proteins and globulins are not unusual and electrophoresis has not shown marked deviation. Cryoglobulins have been absent in two patients studied.

Immunologic studies including ASO titers, heterophiles, and LE preparations are not revealing. Serum complement levels in one patient were normal. Renal autoantibodies<sup>8</sup> were sought in one case with fluorescent antibody technique and were not demonstrated.

Sputum cultures for pathogens have been unrewarding. However, stain of fresh sputums for hemosiderin in most cases have shown macrophages in large numbers, even in some instances, when hemoptysis was not occurring.

Chest x-rays show infiltrates in the majority of patients with a bilateral flocculent density spreading from the hilar regions toward both bases. Rarely pleural effusions are demonstrated and cardiomegaly is not noted. Intravenous pyelograms are normal except for non-visualization in the more advanced cases of uremia. Gastrointestinal series and pulmonary function studies are normal.

### **Syndrome Suspected**

Thus, Goodpasture's syndrome should be suspected in young caucasian males who present with hemoptysis, a marked anemia, and proteinuria. These patients usually develop a rapidly progressing renal failure with azotemia and death. There have been few survivors, and those who did survive did not develop renal failure. One patient in Scheer's series<sup>9</sup> survived 12 years and died of renal failure after the third clinical relapse. Usually the renal lesion is progressive, and death results from renal failure within two years from the first symptoms, if the pulmonary lesion does not predominate.

The median duration of illness in the cases reviewed by Benoit<sup>5</sup> was about 15 weeks with the shorter courses usually associated with fatal pulmonary hemorrhage and the longer courses being associated with renal failure. Rusby and Wilson<sup>4</sup> divided the process into two phases. Phase one is the period in which hemoptysis and anemia are discovered when the sputum is also loaded with hemosiderin laden macrophages, while phase two is the interval beginning with the development of nephritis with hematuria, albuminuria, and cylinduria progressing via a rapid downhill course to a fatal termination.

At necropsy the lungs grossly are large, heavy, and bulky with mottled areas of hemorrhage. Microscopically there is a fairly constant finding of intra-



alveolar hemorrhage with macrophages loaded with hemosiderin. There is a nodular thickening of the alveolar septa but an active vasculitis is not present, a point which is helpful in the distinction between Goodpasture's syndrome and polyarteritis nodosa. Some have described this entity as a necrotizing alveolitis.

Electron microscopy of the pulmonary lesion by Botting<sup>10</sup> revealed an increase in the size and number of epithelial cells that lined the alveolocapillary membrane. Also, large numbers of macrophages were in the alveolar spaces. The basement membranes of both the endothelial and epithelial lining cells showed focal alterations that consisted of a mottled appearance in some areas and deposition of basement membrane-like material in others. Elastic tissues appeared normal in structure but slightly increased in amount.

The kidneys are generally large, soft and have an increased weight with a smooth cortical surface and are covered with small hemorrhagic areas. With long standing renal involvement, there are small kidneys with an adherent capsule.

Earliest Lesion

The earliest lesion seen microscopically is a focal lesion in the tuft involving a portion of the capillary loop which is sometimes occluded by a dense eosinophilic material. There is slight proliferation of the capillary endothelial cells, but more commonly, epithelial cell proliferative changes are noted. This progresses to involve the entire tuft and diffusely involves all glomeruli. Tufts become bloodless and crescent formation becomes prominent. There is an interstitial inflammatory infiltrate, usually lymphocytes, but occasionally eosinophils and plasma cells. The glomerular lesions are progressive to the point of fibrosis with hyalinization.

Electron microscope studies show an increased electron density within the basement membrane of the capillaries. Light microscopy usually shows slight or equivocal thickening of the basement membrane.

The etiology of the lesions found in Goodpasture's syndrome still remains obscure but there is some evidence that immunologic mechanisms may play a role in the pathogenesis of this disorder. Along these lines it is known that certain portions of renal and lung tissue are antigenically similar. It has been shown by Eisen<sup>11</sup> that anti-lung serum contains components, presumably antibodies, which specifically localize in the lung and kidney and that anti-kidney serum has a lung localizing component. This has been shown in rats with radioiodinated anti-lung serum. It has also been shown that the kidney localizing component in anti-kidney tissue serum and anti-lung tissue serum is essentially the same, but the lung localizing properties of the two are different

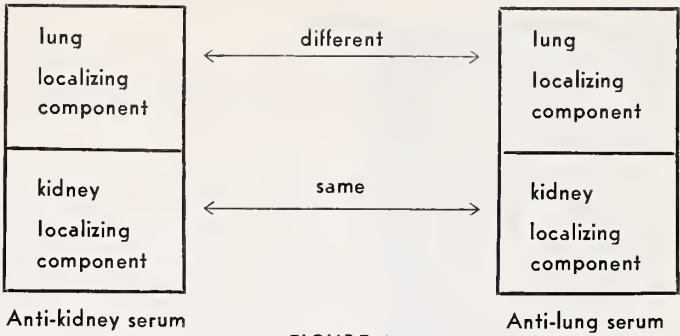


FIGURE 1  
Studies done with radioiodinated anti-kidney and anti-lung serum.

(Figure 1). Furthermore, Hill and Cruickshank<sup>12</sup> have shown with sonic separation techniques that the basement membranes of the glomeruli are responsible for most of the antigenicity of renal tissue in the production of nephrotoxic serum.

Recent studies by Sturgill<sup>13</sup> with fluorescein-labeled antihuman gamma-globulin showed the localization of fluorescence in the glomerular basement membrane and for the first time demonstrated localization of gamma-globulin in the alveolar septa of lung tissue.

Thus, there is sufficient evidence that lung tissue and more specifically, the alveolar septal tissue and kidney tissue, specifically the basement membranes, are antigenically related. The similarity of lung and kidney antigens and the production of experimental nephritis by injection of anti-lung antibody suggests that a mechanism comparable to nephrotoxic serum nephritis may be responsible for the lesions of Goodpasture's syndrome. It might then be postulated that, for some unknown reason, lung tissue may be altered so as to become antigenic with the formation of antibodies that circulate and localize on the basement membranes of the glomerular capillaries resulting in a generalized renal-pulmonary reaction.

No Effective Treatment

The high mortality rate of the process is evidence that, thus far, no effective treatment has been found. Some feel that steroid therapy is indicated,<sup>14, 15</sup> since evidence leans toward Goodpasture's syndrome being an antigen-antibody reaction. It is felt that steroids alter the tissue reaction that occurs when antigen and antibody come together. Fairley<sup>15</sup> presented evidence that those whose predominant process was renal involvement and who received steroid therapy tended to survive longer, and that furthermore, the incidence of massive pulmonary hemorrhage was decreased. He felt that with a rapidly progressing, fatal disease, such therapy should not be denied to this group of patients.

Most recently, Holman,<sup>16</sup> has reported a trial of azathioprine (Imuran®) in a patient with Goodpas-



ture's syndrome but this therapy was not thought to be of benefit.

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\* Dr. Clements is a 1966 graduate of the Medical College of Georgia. The above scientific paper was written as Dr. Clements' senior presentation.

## Conference on Medical Ethics

A SIGNIFICANT PROGRAM of interest to all Georgia physicians is scheduled for December 10 and 11 at Atlanta's American Motor Hotel. The first meeting of its kind ever to be held in the state, the Conference on Medical Ethics is primarily designed for Presidents, Secretaries, and Chairmen of local Professional Conduct Committees (Mediation or Grievance Committees) in an effort to apprise them of some of the ethical problems encountered by today's physician in today's complex society. At the same time, it will offer suggestions for resolving or minimizing these problems.

### Prominent Speakers

A number of well-informed speakers have been secured by MAG's Medical Ethics Committee including Dr. Russell B. Roth, Vice Speaker of the House and Chairman of the Council on Medical Service of the American Medical Association. Dr. Roth will center his remarks around the question of, "Economics or Ethics?"

Explaining the "Establishment and Workings of the Medical Disciplinary Boards" will be the task of Dr. Robert B. Hunter from the State of Washington.

Dr. Hunter's address will give registrants an inside picture on managing and solving unsavory disciplinary situations.

Other topics of interest designed to round out the program will be four separate discussion groups centered around the broad theme of "Facing Up to the Problems." The registrant will choose the topic of his interest and participate in the discussion. These include: (1) Improving Intraprofessional Ethics; (2) Improving Ethics With Our Patients; (3) Handling Professional Conduct Problems; and (4) How to Recognize Legal-Ethical Implications.

The magnitude of ethical and borderline ethical problems facing practitioners of medicine is evidenced by the establishment around the nation of Grievance, Mediation or Professional Conduct Committees. The American Medical Association has long since offered leadership in the area by the establishment of a Department on Medical Ethics, the sponsorship of National Conferences, and the publication of rules, regulations and general information sheets on the subject.

One hundred percent representation by County Medical Societies is the goal. To reach it obviously requires the participation of your society.

## PRESIDENT'S LETTER



# THE HEART, CANCER AND STROKE PROGRAM

**I**N JANUARY 1966, Dr. George Alexander, President, Medical Association of Georgia; Dr. Harry O'Rear, President of the Medical College of Georgia, and Dr. Arthur Richardson, Dean of Emory University School of Medicine, met in Atlanta to activate the program and to appoint an advisory group for developing necessary plans for establishing the regional group for Heart, Cancer and Stroke. These and representatives of 12 other allied and paramedical groups met with Mr. Karl Yordy of the regional medical program staff and outlined the proper future procedure. Dr. Richardson wrote each group requesting appointment of an official representative.

### Steering Committee

A committee composed of Dr. Willis Hurst, Chairman; Dr. Robert Brown; Dr. Gordon Barrow; Dr. Raymond Ahlquist, and Dr. Louis Battey was appointed to draft a proposed plan. This committee, in addition to Dr. J. W. Chambers, named a steering committee to the advisory group.

This group includes dentists, physicians, medical and hospital groups; other health agencies, voluntary health groups and three lay members of the public at large. Many of these members may and do represent more than one organization.

Beginning July 24, 1966, meetings of the entire group have been held every two weeks to study the guidelines, aims and purposes to be accomplished. These were further developed at each meeting.

It was decided by the advisory group at the last meeting (including the original group of 1) Medical Association of Georgia, 2) Emory University School of Medicine, 3) Medical College of Georgia) that the Medical Association of Georgia shall represent them as applicant for the grant and that Dr. J. W. Chambers is to be program co-ordinator, the applicant and program co-ordinator being the responsible fiscal agents.

The following have been appointed co-chairmen of the advisory group: 1) Dr. Arthur Richardson, 2) Dr. Harry O'Rear, 3) Dr. Walter Brown. Dr. Rhodes Haverty, Secretary of the Medical Association of Georgia, is to be fiscal agent. Also to be included in the budget request will be a full time business manager.

### Proposed Budget

A proposed budget for activation of the planning stage has been presented by Dr. Gordon Barrow and adopted after discussion, additions and deletions by the entire group.

It is to be stressed that this portion of the program is for planning only and not for operational grants. The approved budget has been properly executed, signed and forwarded through proper channels to be approved by the Suregon General and President Johnson. This may well call for corrections, explanation of budget items, etc., before final approval of the grant.

The Medical Association of Georgia Executive Committee and Council have also approved leasing of the large assembly room upstairs at the Medical Association of Georgia Headquarters building to Heart, Cancer and Stroke for offices.

This summary is necessarily condensed, and cannot possibly reflect the tremendous amount of time and work spent by many on this new and large program.

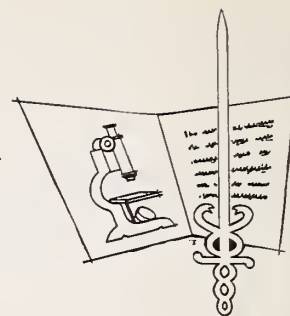
Special credit must be given to Drs. Hurst, Barrow, Battey, Robert Brown, Chambers and Ahlquist, who have given freely long hours of their time to bring the program up to date.

A handwritten signature in cursive script that reads "Walter Brown".

*Walter E. Brown, M.D.*

*President, Medical Association of Georgia*





## THYROID CANCER—PRACTICAL CONSIDERATIONS

Murray B. Lumpkin, M.D., *Dalton*

THE INCIDENCE of thyroid carcinoma is known to vary. Some physicians even consider that it is a rare type cancer; however, a review of the incidence of thyroid cancer in your area can be revealing. The fate of the asymptomatic thyroid nodule should be of interest. A recent statistical analysis of thyroid cancer in New York state reveals that this tumor incidence has more than doubled from 1941 to 1962, representing an increase larger than any cancer of any other site except lung.

### Review Conducted

A review of hospital records for a five-year period was conducted in a medium-sized Georgia community (Dalton, Georgia, Whitfield County—50,000 population). Twenty-two patients were found to have carcinoma of the thyroid. One half had metastasis at the time of surgery. There were 14 follicular adenocarcinomas and eight papillary adenocarcinomas. No giant cell, small cell, or Hurtle cell tumors were in the series. All patients were female and only one patient was colored. All carcinomas presented clinically as a solitary nodule in the gland except for three cases—one occurred in a diffuse goiter and two cases presented as a lateral neck mass. All patients were asymptomatic except for the presence of the tumor. Many were first found by the physician on routine physical examination.

All physicians feel that solitary nodules in breast tissue should be removed. In a large series of breast masses removed, only 6% proved to be malignant. The incidence of malignancy in thyroid nodules in this area far surpasses this percentage. Thirty-two percent of all thyroidectomies performed during the five-year period were for cancer.

There has been some question as to what constitutes the diagnosis of the cancer in the thyroid gland. Pathologists can argue about blood vessel and capsular invasion, but no one doubts that regional

lymph node metastasis means invasive cancer. Eleven of these 22 cases had lymph node metastasis. The lymph nodes involved were of interest in that in all, the superior (Delphian node) or inferior thyroid nodes were involved before jugular nodes became positive.

The ages of these patients were of interest in that 12 of the 22 (55%) cases occurred in the 25 to 35 age group and 18 (90%) occurred in patients less than 45 years of age. Because of the high cure rate and the low age group peculiar to thyroid cancer, radical early treatment is of the utmost importance.

### Total Thyroidectomy

The treatment of thyroid cancer is total thyroidectomy when localized to the gland. Two cases in this series had the thyroid remnant removed after the clinical tumor had been surgically removed. Each of these showed additional nests of malignancy to be present in the remnant which was not suspected initially. Whether this represents intra-glandular metastasis or multi-focal origin is unknown, but does point out the importance of total removal of the thyroid gland.

If the superior or inferior thyroid lymph nodes are clinically involved (and this can be demonstrated by frozen section—not on the gland, but on the enlarged, firm node), a medial neck dissection should be performed. This procedure consists of an en-bloc excision of all lymph nodes from the hyoid bone superiorly to the thymus gland inferiorly and all areolar tissue and lymph glands between the internal jugular veins. The lower margin, that is down to and including a portion of the thymus gland, can usually be removed without division of the sternum. If lateral nodes are positive, a classical radical neck dissection should be done in addition to the total thyroidectomy and the above described medial neck dis-

section. A prophylactic dissection is not warranted. All patients should receive two to three grains of thyroid extract after total thyroidectomy, both as replacement therapy and as an adjunct in the treatment of the malignancy.

### Cause Unknown in Area

The cause of the high incidence of thyroid cancer in this area is unknown. This is not a "goiter area." Only one patient had received x-ray therapy (for

acne) prior to the development of cancer. Perhaps this area had an unusual amount of atomic fallout in the year 1945 before monitoring atmospheric irradiation became universal. *The probable reason for the detection of this high incidence of thyroid cancer in this area is due to the local physician's care and concern over the fate of the asymptomatic thyroid nodule, especially in the young female.*

204 West Waugh Street

*Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.*

## AMA ANNOUNCES PLANS FOR UPGRADING OF U.S. EMERGENCY MEDICAL CARE

The American Medical Association has announced plans for a program designed to bring about what was termed "a vast upgrading" of emergency medical care in the United States.

With hospital emergency room visits up 175% in a ten year period, overall services and facilities "have fallen woefully behind," said Charles C. Edwards, M.D., director of the AMA's division of socio-economic activities.

"The dramatic increase in emergency cases has not been matched with dynamic efforts for a vast upgrading of services," Dr. Edwards declared.

### Uniformity Desired

"We know that emergency service can be excellent. This has been proven in many communities. But there is no uniformity. In other areas emergency service suffers from both lack of coordination and lack of understanding about what constitutes good care.

"A soldier wounded in the jungle of Vietnam often gets quicker, more comprehensive emergency care than an accident victim on the open highway or a farmer stricken by a heart attack."

Acting on a recommendation of its Board of Trustees, the AMA has called together a panel of experts to help organize a national conference next spring that will study and recommend means for improving emergency medical care.

One of the principal tasks of the conference, said Dr. Edwards, will be to unify work already underway by such groups as the American College of Surgeons' trauma committee and the AMA's Council on Rural Health, department of health education and department of hospitals and medical facilities.

Members of the panel invited to meet October 19 at AMA headquarters, include:

Samuel F. Seeley, M.D., and John M. Howard, M.D., of the National Academy of Science; R. R. Hannas, Jr., M.D., of the American Academy of General Practice; Robert H. Kennedy, M.D., and Oscar P. Hampton, Jr., M.D., of the American College of Surgeons; Joseph H. Gerber, M.D., and Joseph K. Owen, Ph.D., of the Division of Accident Prevention, U. S. Public Health

Service; James B. Hartgering, M.D., of the American Hospital Association; Fred C. Dauterich, Jr., of the American College of Physicians; J. E. Brown of the White House Office of Emergency Planning, and George M. Wheatley of the National Safety Council. Also invited were representatives from the American Academy of Pediatrics.

### Four Principal Areas

As envisioned by Dr. Edwards, the conference will delve into four principal areas:

- Ambulance service and the training of ambulance personnel.
- The operation, staffing and equipping of hospital emergency facilities.
- Improved medical education in emergency procedures.
- Further research into the causes and prevention of medical emergencies, whether the result of accident or disease.

"We are faced not with a single problem but with a complexity of problems," Dr. Edwards said.

"These add up to the fact that nationwide too many emergency patients are dying from want of fast and appropriate action—either because their would-be rescuers are inept or because care facilities are inadequate."

Most efforts to improve such conditions have run up against lack of incentive or lack of financing, Dr. Edwards noted.

"This means that in a sense emergency service has been relegated by default to a sidelight instead of a vital function in overall medical care.

"At present we don't even know how many ambulances there are in the nation, let alone how many lives might be saved each year among hundreds of thousands of trauma patients if emergency care were better.

"In any event, it is time we found out what is possible through improved facilities and improved understanding of the nature of medical emergencies.

"We hope that the AMA conference on emergency medical care will help initiate such improvements by stimulating appropriate medical organizations, communities and government at all levels into concerted action."



## EMERGENCY MEDICAL CARE/Continued

The price tag for such a program would undoubtedly be considerable, he conceded. "Emergency service is costly. But on the other hand, it is not nearly as costly as the high price of death in terms of both actual and economic loss.

"For example, the price of a young man's death in an accident—if you can put a price on life—goes beyond funeral expenses. There is a loss of productivity that when multiplied by tens of thousands of such deaths each year gnaws at the strength of the nation. There is a loss of income to his family, which in many instances has to be partially made up by public funds in terms of aid and assistance. And, there is a loss of opportunity for the man's children if, for instance, his death means they can't go to college."

### A Haphazard Approach

An analysis of "our less than adequate" state of emergency care by Richard F. Manegold, M.D., director of the AMA's department of hospitals and medical facilities, indicates that much of it may spring from a "fragmented haphazard approach."

"Because a man has a driver's license doesn't mean he is competent to drive an ambulance," Dr. Manegold said. "After all he's not delivering goods, like a laundry man, but sick and injured people.

"Often he has vital decisions to make. Should a patient with a broken back be moved, or should more qualified help be sought? Is mouth-to-mouth respiration needed? Is the patient in shock? Can bleeding be controlled?

"Unless ambulance drivers understand such things, a life that could be saved might slip away. And yet many ambulance drivers don't even know the rudiments of first aid.

"What is obviously necessary is a program to develop personnel for civilian use similar to army medical corpsmen. They would either accompany ambulances or serve as ambulance drivers."

### More Elaborate Equipment

Along with trained technicians for ambulances, Dr. Manegold also suggested more elaborate equipment.

"We can now monitor heart beat, blood pressure and respiration of astronauts in space. It seems to me that similar facilities for ambulances could provide information on a patient's condition before he even gets to the hospital. Another important piece of equipment might be a cardiac pacemaker similar to those now in use in intensive care units of hospitals."

Turning to the subject of hospital emergency departments, Dr. Manegold said, one of the greatest needs was for "coordination of services."

"Emergency rooms must be geared to community requirements, rather than based on some nebulous factor such as hospital size," he said.

In this context it is neither necessary nor desirable that all hospitals have the same type emergency facilities. If a particular hospital is well equipped to handle accident emergencies, it might then be better if the hospital across the street organized its emergency department to handle cardiac emergencies, he explained.

"With a little coordination we can see to it that one area isn't overloaded with a particular type of emergency facility while another area does without.

### To Make It Worthwhile

"This is not always the case today," he said. "For example, cardiac surgery rooms became a sort of status symbol for hospitals. Some went to great expense setting up such facilities and staffing them with highly-skilled teams only to find that they didn't receive enough cases for surgery to make it worthwhile keeping the team together."

Smaller communities in particular sometimes have special needs in regard to emergency facilities. "We get some indication of this from the fact that 70% of all auto accident deaths occur in communities of 2,500 or less. In part the higher death rate may be due to the fact that distances are so much greater. But lack of staff and equipment in many small hospitals is also a factor, I think."

### Fallacious Correlation

The problem is that the size of the emergency department is usually based on the size of the hospital when in fact no such correlation can be made. "Because a community may need only a 25-bed hospital doesn't mean that a first aid room can serve as an emergency department," he said. "Other factors have to be taken into consideration—the proximity of a major highway, for instance."

In addition to all this, there is also the situation created by what Dr. Manegold referred to as "the use of emergency facilities as an after hours doctor's office."

"People with chronic complaints or with nothing more pressing than an ingrown toenail can be found in almost every emergency room. This is fine if a hospital can handle such complaints. But in many instances such non-emergencies may so overload emergency facilities that when the trauma patient arrives the institution can't respond with adequate care."

### Facilities Not Enough

Of course facilities alone are not enough without physicians to staff them. Inadequate staff—or what amounts to almost the same thing, inadequate scheduling of staff—can be just as deleterious to good emergency care as an overtaxed emergency room or an ambulance driver who doesn't know how to apply a tourniquet, Dr. Manegold said.

Moreover, he believes that all physicians must be competent in emergency techniques, yet some enter into the practice of medicine without ever having worked in an emergency room.

"This is wrong," he said. "No intern should leave training without experience in emergency care. At the same time we must provide the wherewithal for continuing education so the practicing physician can learn new emergency techniques as they are developed."

"We have in the nation today bits and pieces of exemplary emergency care," he added. "Our objective now is to see that this same degree of care is provided in all communities."



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\*Multiple of adult Minimum Daily Requirement supplied.

†The need for these substances in human nutrition has not been established.

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## TREATMENT OF UREMIA WITH CHRONIC HEMODIALYSIS

John H. Sadler, M.D., *Atlanta*

**C**HRONIC HEMODIALYSIS is no longer a research technique, but a means of treatment for chronic uremia. It is now operating in Georgia at the Atlanta Artificial Kidney Center.

### Cost and Need

This Center, within the Emory framework, is one of several funded by the U. S. Public Health Service to determine the cost and extent of need for such treatment. Federal funds are granted for the pilot period of three years, after which local support will have to be found.

Chronic dialysis does not represent a cure, but a treatment with certain limitations, permitting rehabilitation of the chronic uremic.

### Indwelling Shunt

What are these limitations? First, an indwelling arteriovenous shunt of silastic and teflon, which may be opened to attach the patient to the artificial kidney without repeated surgery. This shunt requires care, daily cleaning and dressing. Clotting, bleeding and infection can occur from this cannula, associated with the intermittent heparinization required for dialysis. The average life of a shunt is about nine months.

Secondly, dialysis must be carried out overnight twice weekly on a regular schedule. This time is lost from usual activities.

Finally, the low protein, low sodium, low potassium diet must be continued since the patient still does not have excretory ability between dialyses.

Within these limits, patients on chronic dialysis are not ill. Uremia is minimized, and hypertension can be controlled. Pruritis, nausea and irritability are relieved. Anemia may moderate, but periodic transfusions are still required. Neuropathy, if present,

does not usually clear. Uremic bone disease is often improved, but not cleared.

A patient fitting this description is not normal, but can be comfortable and productive.

### Patient Selection

Most uremic patients are not suitable for chronic dialysis because they have other diseases which dialysis cannot treat. The well-motivated patient without other disease, who is employable when freed of his uremic symptoms, and who has a helpful, realistic family, is the ideal candidate. This ideal occurs rarely. Still, there are more medically qualified patients than space in programs. Cost of dialysis is high, at \$8,000 to \$12,000 per year. The Center must select the best patients for successful rehabilitation now, while finding ways to make the program available to those who need it.

Home dialysis, for those capable of it, can reduce the cost. Transplant research may yield answers. Now, expensive and limited though it is, there is an effective treatment, and this represents a major step forward.

The Atlanta Center can treat patients living within commuting distance—roughly, 50 miles. They must be within the ages of 20 and 45, and free of chronic illness such as heart disease, diabetes, peptic ulcer or stroke. They must be referred through a consulting nephrologist. The Center can take five patients in 1966, ten more in 1967, and 15 more during 1968, when all necessary equipment and personnel will be in place.

*Department of Medicine  
Emory University School of Medicine  
Grady Memorial Hospital*

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

## DIGITALIS—WOULD FDA APPROVE IT TODAY?

... I would hate to be introducing digitalis as a new drug today. Anyone reading the toxicity and side effects would never use it in the present climate. However, digitalis has been with us long enough now that the toxicity and side effects have taken their proper place.

They are there, to be sure, but not as prominently as the therapeutic effect.—Robert W. Ballard, M.D., in *Food Drug Cosmetic Law Journal* (21:31-32), January 1966.

**Many overweight patients  
can benefit from the appetite  
control provided by the sustained  
anorexigenic-tranquilizing  
action of BAMADEX SEQUELS:  
anorexigenic action of  
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## **Bamadex® Sequels®**

DEXTRO-AMPHETAMINE SULFATE (15 mg.) SUSTAINED RELEASE CAPSULES  
WITH MEPROBAMATE (300 mg.)

**to help establish  
a new dietary pattern**

**Contraindications:** Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

**Precautions:** Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side Effects:** Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.



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**Contraindication**—History of hypersensitivity to tetracycline.

**Warning**—If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, tetracycline serum level determination may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment and treatment should be discontinued at first evidence of skin discomfort.

**Precautions**—Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.

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### CHRONIC ALCOHOLISM—A LEGAL DISEASE

John L. Moore, Jr., *Atlanta*

#### *R*ecent Cases

In January, 1966, the United States Court of Appeals for the Fourth Circuit struck down a North Carolina state court conviction of a chronic alcoholic for the crime of public drunkenness. At the end of March, 1966, the United States Court of Appeals for the District of Columbia Circuit held that a chronic alcoholic could not be convicted of public drunkenness. However, in July, 1966, the Court of Appeals of Michigan stated that it did not believe it to be cruel and unusual punishment to imprison a man for public drunkenness over a claim that he was a chronic alcoholic.

#### The Issue

Is chronic alcoholism a disease? The Federal Courts thought so. In past years it has universally been held by courts in the United States that a person is responsible for his acts while intoxicated. The reasoning states that a person is responsible for his own intoxication because he could have declined to take the first drink.

#### Federal Court Holding

The two Federal Courts mentioned both decided that the older principles mentioned above are no longer true. The District of Columbia Court referred to a 1947 Act of Congress relating to the District of Columbia which specifically stated that a chronic alcoholic is a sick person in need of treatment. That 1947 Act also recited as its purpose "to substitute for jail sentences for drunkenness medical and other scientific methods of treatment which will benefit the individual involved and more fully protect the public." The Court of Appeals in the District of Columbia realized that there had been no implementation of that purpose by the opening of treatment facilities for chronic alcoholics. However, the Court said that that made no difference.

The Fourth Circuit, however, was dealing with the State of North Carolina which had not adopted

any statute specifically defining chronic alcoholism as a disease. It simply relied on definitions propounded by the American Medical Association, the National Council on Alcoholism, and the World Health Organization. Since chronic alcoholism is a disease, the Federal Courts reasoned that it was cruel and unusual punishment to inflict even a suspended fine upon a chronic alcoholic convicted of drunkenness. The Courts said that an essential element of a crime such as public drunkenness is a "guilty mind" and that a person who cannot, because of disease, resist taking a drink cannot be held to have the requisite "guilty mind."

#### Court Did Not Agree

The Michigan court did not agree. However, in the particular case involved, it did not find sufficient evidence to persuade it that the defendant was a chronic alcoholic. He was only convicted of a third offense of public drunkenness. In the two Federal cases the evidence of chronic alcoholism was so strong as not to be tested by the prosecution. In the North Carolina case the defendant was 59 years old, his first conviction for public intoxication occurred at age 24, and since that time he had been convicted of the offense more than 200 times. In the District of Columbia case the defendant in the past 30 years had been arrested for intoxication 70 times, hitting an all time record of 12 times in the calendar year 1963. In both cases the defendants existed in the face of broken home lives, recurrent hospitalization, and loss of steady employment.

#### Implications

It appears to this writer that there are broad implications of the two important Federal decisions. The important District of Columbia Court of Appeals referred to general principles of criminal law in discussing the concept of the "guilty mind." The analysis applied to the crime of public drunkenness would apply equally to other crimes committed by



a chronic alcoholic while intoxicated. One can think of driving under the influence, murder, robbery, and other crimes of violence. If this should turn out to be the holding of subsequent cases, it is almost certain that states will have to move rather promptly to provide involuntary hospitalization of chronic alcoholics.

One further and more far reaching implication can be detected. If chronic alcoholism is recognized as a disease negating the "guilty mind" which is required for a conviction of a crime, why should not other diseases affecting conscience or volition also provide a defense to charges of the performance of such crimes? Is it possible that the courts will say in the future that the sociopath did not have a "guilty mind" in forging the check because he had lost the power of self-control with respect to forging checks as a part of his sociopathic personality?

**Georgia Statutes**

The Health Code of Georgia states, in § 88-401, that "alcoholism is hereby recognized as an illness and a public health problem affecting the general

welfare and economy of the State." In § 88-402 an "alcoholic" is defined to mean "any person who chronically and habitually uses alcoholic beverages to the extent that he has lost the power of self-control with respect to the use of such beverages or while chronically or habitually under the influence of alcoholic beverages endangers public morals, health, safety, or welfare."

It should be emphasized that the Federal court having jurisdiction over the State of Georgia has not yet ruled in this area. However, it is almost certain that a case of the same nature will be taken to that court in the near future to test the principle already established in the Fourth Circuit covering the States of South Carolina, North Carolina, Virginia, West Virginia, and Maryland, as well as the principle established in the District of Columbia by its own Court of Appeals.\*

*Suite 1220 C & S Bank Building*

\* The cases discussed are *Driver v. Hinnant*, 356 F. 2d 761 (4th Cir. 1966), *Easter v. District of Columbia*, 361 F. 2d 50 (D. C. Cir. 1966); and *People v. Hoy*, 143 N. W. 2d 577 (Ct. App. Mich. 1966).

Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

**MAG APPLIES FOR HEART, CANCER, STROKE GRANT**

In accord with the recommendations of the Advisory Group to the regional Medical Program for Heart Disease, Cancer, Stroke and Related Diseases, the MAG Council voted to represent the Advisory Group as "Applicant" for a planning grant to carry out the purposes of this program. The Advisory Group is composed of representatives of some 18 health care organizations and agencies including the Medical College of Georgia and Emory University School of Medicine.

**The Main Purpose**

The main purpose of this Regional Medical Program (Public Law 89-239) is to develop a plan that will correlate the activities of the various organizations and agencies and extend these activities in creative and innovative ways—so that the long range effect will be the improvement of the care of patients in Georgia.

MAG Council also approved the appointment of J. W. Chambers, M.D., LaGrange, as Program Coordinator for this "planning grant," as recommended by the Advisory Group. MAG as Applicant and Dr. Chambers as Program Coordinator will serve as agents for the organizations comprising the Advisory Group. During the "planning phase" of the program, qualified personnel will be employed to develop an operational plan to meet the objectives and requirement of the law. Accordingly, the next phase of the program is to apply for an "operational grant" to put these plans into effect in Georgia.

In the broadest sense, this program will achieve an environment for continuing health care education throughout the state as it relates to heart disease, cancer

and stroke. The MAG Headquarters Office Building will be used as office space for the program personnel.

It is important to note at this writing, that the program will only become effective on approval of the grant application which was submitted October, 1966. MAG will be informed as to whether or not the application received approval early in December of this year.

**NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA**

Abernathy, A. H., III Active—Fulton	1938 Peachtree Street, N.W. Atlanta, Georgia 30309
Barton, Dewey L. Active—South Georgia	Doctors Building Valdosta, Georgia 31063
Bridges, Glenn J., Jr. DE-2—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303
Brooks, Thomas W., III Active—Washington	524 Sparta Road Sandersville, Georgia 31082
Cardin, Mary Jean DE-2—Fulton	1968 Peachtree Road, N.W. Atlanta, Georgia 30309
Carlisle, O. B. Active—Fulton	705 Juniper Street, N.E. Atlanta, Georgia 30308
Finklea, John L. Active—Sumter	205 S. Lee Street Americus, Georgia 31709
Jones, Edwin L., Jr. Active—Fulton	478 Peachtree Street, N.E. Atlanta, Georgia 30308
Kushner, Robert L., Jr. Active—Cobb	642 Cherokee Road Smyrna, Georgia 30080
Lange, Stephen J., Jr. DE-2—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303



## THE FAMILY PHYSICIAN AND PSYCHOTHERAPY

M. D. Pittard, M.D., *Toccoa*

**I**N HIS PAPER, "The Initial Interview as a Therapeutic Process," presented at the Medical College of Georgia, Dr. M. B. Sell described a technique whereby a patient may be benefited from one or two visits by: (1) getting the family to begin communication; (2) having them discuss the immediate problem; and (3) the active participation of the therapist.

### Benefited by Family Physician

Many patients are benefited in just such a manner by the family physician, either with or without his realization as to just what has occurred or why it has happened. Frequently, the patient fails to return because he has been able to see his problem more clearly and either accept it or begin to correct it. Of course, he may also fail to return because of the indifference of the doctor to his problem or the lack of an opportunity to discuss it. Another reason for our failure to appreciate the benefits of our discussion with disturbed patients is a tendency to erroneously credit improvement to prescribed drugs.

The involvement of the spouse in the interview situation would appear to be more important than I had realized. It now seems obvious that some of my past successes have been the result of just such participation by the spouse. Whereas, I do not think this technique is essential, there are obvious ad-

vantages, the primary one being that of communication between marital partners.

The most frequent reason given by the family physician for not utilizing psychotherapy and counselling is the amount of time involved. I admit that this is a problem, but *not* a valid reason! I submit that over the long term, less of the physician's time will be usurped by the emotionally disturbed if he will "let them talk," than if he merely treats recurring symptoms, never getting to the bottom of the difficulty and often forcing the patient to seek help elsewhere.

### First Line of Defense

The family doctor must serve as the first line of defense against mental illness. There are not enough psychiatrists to do the job. There is no reason why the majority of the mentally ill cannot be treated in their "own" communities by their "own" doctors. We must accept this responsibility by: (1) learning to recognize the problem; (2) accepting our limitations but learning to be comfortable with them; and (3) most important of all, learning to accept these patients as people in trouble who need, deserve, and are entitled to our help.

*Toccoa Clinic*

Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.

## COBB MEDICAL SOCIETY TO HOST CALIFORNIAN FOR FEBRUARY MEDICINE & RELIGION SYMPOSIUM

The Cobb County Medical Society, through its Committee on Medicine and Religion, will sponsor a symposium, "The Eastern View of Man" for physicians, clergymen and lawyers in Marietta, Thursday, February 23, 1967.



Dr. Alan Watts

The principal speaker will be Dr. Alan Watts, President, School of Comparative Philosophy, San Francisco, California, an authority on Eastern (Oriental) religion and philosophy, and author of more than 15 books including, *The Wisdom of*

*and West*. The symposium will begin at 2:00 p.m. with the initial presentation by Dr. Watts followed by discussion groups under the leadership of members of the three disciplines included in the symposium. Wives are invited and encouraged to attend.

For full details and a complete program including a reservation form for the dinner and evening session (no reservation needed for afternoon program), please write Dr. Mark Gould, 2932 South Atlanta Road, Smyrna, Ga., or Dr. Noah Meadows, 208 Tower Road, Marietta, Ga. Dinner reservations will be limited to the first 500 received.

*Insecurity, The Way of Zen, and Psychotherapy—East*





## What does he drive home from work?

He drives the same kind of car he's been driving all day at the track — Porsche. A car driven by *people*, not push buttons.

He knows Porsche is a car *he* can control. The aircooled engine, of lightweight aluminium alloy, is in the rear for greater traction. It may be a midget by Detroit standards. But it powers the car, not gadgets.

Power is put into action by an improved 4-speed gear box (5-speed if you want it). Its smooth, even shifting action



makes it as automatic as he wants it to be. His profession demands a car that will hold the road. Porsche's safe, precise steering and torsion bar suspension keep him in command — at any speed, on any surface.

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The new Porsche. It's an exciting car to drive. On the track.

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# Porsche

Porsche 911.6 cylinder engine, 148 horsepower, 5-speed synchromesh, (5-speed optional), top speed 130 mph.  
Porsche 912.4 cylinder engine, 102 horsepower, 4-speed synchromesh, (5-speed optional), top speed 115 mph.



**Norris, Jack C., M.D., 490 Peachtree St., N.E., Atlanta, Ga., "Mononucleosis: Pertinent Points and a Simple Diagnostic Aid," Southern Medical Journal 59:1067-1070 (September)1966.**

The paper deals in generalities about the malady, with a brief discussion of the historic background, including symptomatology, pathology and diagnosis, pointing up the use of the Thymol turbidity and Wompole Mono Test. Dr. John B. Riggsbee's method of treatment is included. The final point is raised for evaluation: "Is Mononucleosis truly a lymphnodal type of fever, or isn't it a subtle form of Hepatitis of viral character?"

**Rieser, Charles, M.D. and Deitch, Milton J., M.D., Emory Univ. Hospital and Grady Mem. Hosp., Atlanta, Ga., "Value of Renal Angiography in Everyday Urologic Practice," The Journal of Urology 96:24-30 (July)1966.**

The introduction of a new method of diagnosis requires several years of clinical application before the advantages, risks and disadvantages may be fundamentally evaluated as to its practicality. This problem seemed particularly pertinent in relation to renal angiography, a procedure which seemed to captivate intense interest in those confronted with diseases of the kidney. In an attempt to categorize this question from the viewpoint of the urologist, a critical study of 226 examinations performed at Grady Hospital was undertaken. The following deductions were made.

When renal infection existed and pyelography by any technique seemed normal, angiography was decidedly helpful in demonstrating subtle obstruction and chronic pyelonephritis. When pyelography was technically not feasible or visualization of the kidney impossible, angiography was capable of demonstrating vascular distribution and functional capacities of the renal parenchyma. The greatest usefulness of the procedure became evident in detailed differentiation of mass lesions such as cysts of various types versus neoplasms. Specific help was provided in estimating the extent of laceration of the renal parenchyma in instances of trauma.

In conclusion, and considering the time, expense, elaborate equipment and technical knowledge required, renal angiography should be reserved for those lesions which cannot be adequately demonstrated by standard diagnostic techniques.

**Eberhart, Charles, M.D. and Morgan, J. W., M.D., Dept. of Urology, Emory Univ. School of Medicine, Atlanta, Ga., "Persistent Urinary Infection Following Vesical Neck V-Y Plasty," Southern Medical Journal 59:1004-1006(September)1966.**

V-Y plasty is the most satisfactory method of alleviating functional obstruction at the vesical neck. The op-

eration has been employed extensively in children and adults, many of whom suffer from recurring episodes of cystitis and/or pyelonephritis. In spite of a good functional result, some individuals have persistent urinary infection. While trying to find an explanation for this paradox, it was found that bacteria persist for months or years, apparently in a microscopic, intramural lesion at the site of the V-Y plasty incision in the detrusor vesicae. The presence of this focus can be demonstrated by thoroughly cleansing the bladder by irrigation or chemotherapy and massaging the V-Y plasty area. Massage is done via the rectum in children and men, and via the vagina in women. The bladder is then rinsed with 15 ml. of irrigating fluid and the sediment of this fluid is examined microscopically. Many squamous epithelial cells are frequently present. The presence of pus cells, free or clumped, is indicative of an intramural lesion. This lesion can frequently be eradicated by repeatedly massaging the area while maintaining the patient on a suitable medicant.

**Blanchard, Thomas W., M.D.; Rinker, J. Robert, M.D., and McLendon, Rembert L., M.D., Section of Urology, Medical College of Georgia, Augusta, Ga., "Cutaneous Ureterostomy Following Blockage of the Ureteral Vasculature: An Experimental Study," The Journal of Urology 96:39-43(July)1966.**

In a series of female dogs, electrocoagulation of the left intramural ureter was carried out seven days prior to bilateral cutaneous ureterostomy. The survival rate of the ureters was compared. Not a single ureter so treated failed to remain healthy and patent following transplantation to the skin. All but two of the untreated mates sloughed and stenosed. It appears that this procedure would be applicable clinically where permanent urinary diversion is necessary.

**Rinker, J. Robert, M.D. and Blanchard, Thomas W., M.D., Medical College of Georgia, Augusta, Ga., "Improvement of the Circulation of the Ureter Prior to the Cutaneous Ureterostomy: A Clinical Study," The Journal of Urology 96:44-48(July)1966.**

The principle has been previously established experimentally that if the circulation of the in situ ureter is blocked, the vascular plexus will open up, resulting in good end circulation down to the vascular obstruction. When applied clinically by electrocoagulation of the ureter or transurethral resection of the intramural ureter, the circulation of the distal end is improved so that less chance of slough occurs when the ureter is transplanted in cutaneous ureterostomy. The ureters in six consecutive patients were successfully transplanted without slough, increasing the chances of a successful operation.

**Josey, Wm. E., M.D.; Hoch, Willis, M.D.; Moon, Elliott C., M.D., and Thompson, John D., M.D., Depts. of GYN-OB and Pathology, Emory Univ. School of Medicine, Atlanta, Ga., "Analysis of 21 Septic Abortion Deaths with Special Reference to the Shwartzman Phenomenon," Obstetrics and Gynecology 28:335-341(September)1966.**

During the 15 year period 1949 through 1963, there were 21 cases of fatal septic abortion at Grady Memorial Hospital. Autopsy was performed in 19 cases. From careful review of the hospital course, laboratory data, and pathology reports, the causes of death were classified as follows: gram-negative bacteremia in 11, *Clostridium perfringens* sepsis in 5, a combination of gram-negative bacteremia and *Clostridium perfringens* sepsis in 1, perforated uterus with generalized peritonitis in 1, pelvic thrombophlebitis and retroperitoneal abscess in 1, tetanus in 1, and pulmonary embolism in 1. In 5 of the 12 patients dying from gram-negative bacteremia, the clinicopathologic manifestations were compatible with the generalized Shwartzman reaction.

**Van Duyn, John, M.D., Doctors Building, Columbus, Ga., "Plastic Surgery at the Albert Schweitzer Hospital, Haiti," Southern Medical Journal 59:1033-1035(September)1966.**

Because the Republic of Haiti only recently had the specialty of plastic surgery available, there are not only the usual cases which add themselves regularly to the population, but in addition, a backlog of untreated old ones. It is the existence of these old cases especially that makes a medical visit to Haiti so rewarding. To see what happens, for example, in harelip cases in which the patients have reached adulthood untouched is almost worth the trip in itself.

Of 18 patients operated on at the Albert Schweitzer Hospital, 9 were for cleft lip and/or palate; 7 had assorted tumors or disfigurements of the face; the remaining 2 were a burn scar of the hand, and a thigh stump problem, respectively.

In 3 adults with complete unilateral cleft lip, ranging in age from 17 to 30 years, it was found in closing the lip defects that the relatively larger size and greater stability of the lip segments in adults made for easier planning but, on the other hand, for greater difficulty in adjusting the less mobile flaps after the cutting.

A visit to the still mysterious and exotic country of Haiti under the auspices of one of the plastic surgical societies can be an enriching experience.

**Wenger, Nanette Kass, M.D.; Miller, Frederick Monroe, D.D.S., and Brim, Alice, B.S., Dept. of Medicine, Emory Univ. School of Medicine, Atlanta, Ga., "A Study of the Oral Flora in Children Receiving Sulfadiazine Prophylaxis Against Rheumatic Fever,"**



## ABSTRACTS/Continued

*American Heart Journal* 72:420-422(September)1966.

Continuous chemoprophylaxis against streptococcal infection is recommended to prevent recurrent rheumatic fever; oral sulfadiazine and penicillin have proven equally effective as chemoprophylactic agents. However, penicillin prophylaxis produces significant alteration of the normal oral flora. This study was designed to evaluate the effect on the oral flora of long-term continuous sulfadiazine prophylaxis. The study group consisted of 21 children with inactive rheumatic heart disease who were receiving sulfadiazine prophylaxis as recommended by the American Heart Association for at least six months; the average duration of prophylaxis was two and one-half years. No child received penicillin or other antibiotic for at least 30 days prior to study. The control subject for each patient was a child of the same sex next on the class roll at school, who had received no antibiotic for 30 days prior to study. Culture and smear of the mouth and throat were performed in a standardized manner. Cultures were evaluated for alpha streptococci, coagulase positive staphylococci, neisseria, yeast and lactobacilli; smears were examined for fusiform bacilli and spirilla. There was no significant difference between the sulfadiazine and control groups in the occurrence of coagulase positive staphylococci, neisseria, lactobacilli, yeast, fusiform bacilli or spirilla. Cultures for alpha streptococci were positive in all children in both groups; however, an increased number of alpha streptococci were cultured from the children receiving sulfadiazine. The sole difference in the oral flora between 21 children receiving sulfadiazine prophylaxis and the control group was an increased number of alpha streptococci, significant only at a 5% level. The absence of major alteration of the oral flora makes long-term continuous sulfadiazine the preferred chemoprophylaxis against recurrent rheumatic fever.

*Flinchum, Darius, M.D., 340 Boulevard, N.E., Atlanta, Ga., "Patellectomy: When, Why and How?" Southern Medical Journal* 59: 897-900(August)1966.

Patella removal is indicated in all cases of severely comminuted patellar fracture and also in some cases of osteoarthritis, chondromalacia, osteochondritis dissecans, tumors and deformities.

A simple operative technic is presented. Through a small, medial, transverse incision the patella is excised, leaving the patellar tendon expansion intact and advancing the vastus medialis muscle in order to give secure extension of the knee and allow good flexion early.

In a few cases postoperatively the patellar tendon and muscle transfer require tightening.

Fifty-eight operative cases are reviewed, and in general very satisfactory results have been obtained.

*Mosley, James W., M.D. and Dull, H. Bruce, M.D., Epidemiology Branch, CDC Atlanta,*

*Ga., "Transfusion-Associated Viral Hepatitis," Anesthesiology* 27:409-416 (July-August)1966.

The terms "transfusion-associated" and "post-transfusional" hepatitis have appeared recently in the medical literature. Their popularity is due to the unexpected frequency with which recent series of cases have uncovered incubation periods shorter than those traditionally associated with serum hepatitis. Review of incubation period in data available to CDC indicates that it may be as short as 10 days in a few instances. Almost one-third of cases have incubation period shorter than 50 days.

Blood and blood derivative may be classified according to their risk of transmitting viral hepatitis. "Average risk" applies to whole blood and its derivatives which are neither pooled nor treated. In various series, the attack rate produced by average risk materials has ranged from 0.6% to 6.2%. "High risk" materials include irradiated pool plasma which has not been otherwise treated, fibrinogen and antihemophilic globulin. They are high risk products because of pooling and the failure of treatment to inactivate the agents of viral hepatitis. "Safe" materials are derived from plasma pools, but are of such a nature that they can be adequately treated to inactivate any virus which may contaminate them.

Several approaches to reducing the incidence of transfusion-associated hepatitis can be specified. Icteric materials should not be used at all unless they are clearly needed. If whole blood or other average risk materials must be used, the minimum amount which will accomplish the purpose should be given. A high risk blood derivative should not be used if it is not specifically needed.

Available evidence to date is not sufficiently suggestive to warrant administration of immune globulin in an attempt to prevent transfusion-associated hepatitis.

*Olansky, Sidney, M.D., Dept. of Medicine, Emory Univ. School of Medicine, Atlanta, Ga., "Some Aspects of the Management of Venereal Disease," Archives of Environmental Health* 13:376-380(September)1966.

The resurgence of syphilis makes its diagnosis and treatment of obvious importance.

The diagnosis of early syphilis, when typical, requires little emphasis. Some less typical cases are reported as illustrations.

Penicillin remains the treatment of choice in all stages of syphilis and when patients are sensitive to penicillin, erythromycin 20 to 30 gm. or tetracycline 30 to 40 gm. given over a 10-15 day period at a rate of 2 gm. a day is good reasonable therapy.

In the research area experimental infections in primates should produce useful information on the natural course of the disease, new aspects of serologic testing, and the possible role of a vaccine.

The situation in gonorrhea is not very optimistic, although research is being done on new methods of therapy and particularly better methods of early diagnosis.

*Williams, R. C., Sr., M.D., Hospital and Health Planning Department, Community*

*Council of the Atlanta Area, Inc., Atlanta, Georgia, "William H. Sanders, M.D., Early Leader in Medical Education and Public Health Work in Alabama," Journal of the Medical Association of the State of Alabama, Journal of the Medical Association of the State of Alabama,* 139-146(August)1966.

One of the outstanding leaders in the medical education and early public health work in Alabama was Dr. William H. Sanders, a native of Tuscaloosa, Alabama, where he was born in 1838. After receiving his medical degree in 1861 from Jefferson Medical College in Philadelphia, Dr. Sanders returned to his home in Alabama, and was appointed assistant surgeon of the 11th Alabama Infantry Regiment. Shortly thereafter, he was assigned to the army of Northern Virginia where he served throughout the war.

After the Civil War, Dr. Sanders returned to his home in Clinton, Greene County, Alabama. He practiced medicine there until 1873 when he went to Europe to broaden his professional training.

Dr. Sanders worked in hospitals and laboratories in Germany, Austria, France, and England for four years. He returned to the United States in 1877 and located in Mobile, Alabama, to begin practice in the specialty of diseases of the eye, ear, nose and throat. Soon after coming to Mobile, Dr. Sanders became a member of the faculty of the Medical College of Alabama, which was established in Mobile in 1859. He was a member of the faculty there for 34 years. Dr. Sanders brought back from Europe first hand knowledge of the important work being done by Pasteur and Koch in the new field of bacteriology and also the use of antiseptics and asepsis in surgery by Lister in London.

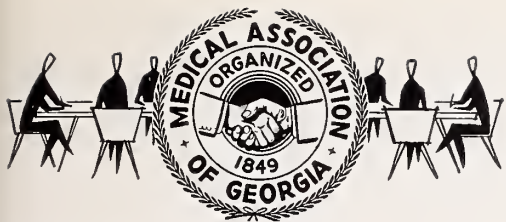
Upon the death of Dr. Jerome Cochran, the first State Health Officer, in 1897, Dr. Sanders became State Health Officer. He spent Thursday and Friday of each week meeting classes at the School of Medicine of the University of Alabama in Mobile during the periods when classes were in session.

As the second State Health Officer of Alabama, Dr. Sanders served in that capacity for 20 years, 1897-1917, Yellow fever had ravaged the states of the southern area since the colonial period. Smallpox was still common in many states when he came into office. Typhoid fever and malaria exacted a heavy toll. This was a period of progress from empirical medicine to scientific medicine. Because of ill health he resigned as State Health Officer in 1917. He died January 2, 1918, in Montgomery, Alabama.

Dr. Sanders exemplified to all who came in contact with him qualities of loyalty, integrity and pride in the profession of medicine that are so important to guide every physician throughout his entire life.

His work as a medical educator, his leadership in medical organization activities and public health were of incalculable value to the people of the state he loved and served so faithfully and well.





# THE ASSOCIATION

## DEATHS

**William H. Bateman**, 50, former Forest Park mayor, died September 27, 1966.

Dr. Bateman served on the Forest Park City Council from 1961-1963 and was mayor in 1964-1965. He was defeated for re-election last year.

A graduate of the University of Georgia School of Medicine at Augusta, he maintained offices in both Atlanta and Forest Park.

Born in Deepstep, Georgia, he was a Navy veteran of World War II, serving in the Medical Corps. He was a member of Theta Kappa Psi medical fraternity, the Fulton County Medical Association and the Forest Park Rotary Club.

Survivors include his wife, the former Agnes Baskett; three sons, William H. Bateman, Jr., Joseph W. Bateman and Clifford Veal Bateman; two daughters, Miss Jane Louise Bateman and Miss Kitty Sue Bateman, all of Forest Park; mother, Mrs. Needham B. Bateman, Sandersville; three brothers, Dr. Needham B. Bateman, Jr., Jonesboro; Dr. Gregory Bateman, Atlanta, and Dr. Osgood M. Bateman, Sandersville, and a sister, Mrs. Troy Edwards, Eatonton.

**J. Harry Lange**, an Atlanta and Chamblee pediatrician died September 3, 1966. He was 55.

A native of Savannah, Dr. Lange received undergraduate and medical degrees from Emory University, and trained at several Atlanta hospitals.

He later was a staff member of Emory, Piedmont, Crawford Long, Georgia Baptist, St. Joseph's and Egles-ton hospitals, and had offices in Chamblee and on Lindbergh Drive N.E.

Dr. Lange served in a hospital unit in Africa and Europe during World War II, and was a member of several professional societies.

In addition, he was a past president of the Georgia Pediatric Society and a past chairman of the Georgia chapter of the American Academy of Pediatrics.

Dr. Lange was a member of the Sigma Nu Fraternity, the Phi Chi medical fraternity, the Capitol City Club and the University Yacht Club. He was an elder of the Trinity Presbyterian Church.

Surviving are his widow, the former Letitia Rockmore; sons, J. Harry Lange, Jr. and Emmett R. Lange of Atlanta; sisters, Mrs. G. B. King, Mrs. Annie L. Henderson and Mrs. L. L. King, all of Savannah, and a nephew.

## COUNTY MEDICAL SOCIETIES

Three Middle Georgia physicians were accepted for membership in the **Bibb County Medical Society** September 6, 1966.

They are Dr. Henry W. Harper, a Macon anesthesiologist, Dr. Patton Paul Smith, a Forsyth general practitioner, and Dr. Jack F. Nenendez, a Macon general surgeon, specializing in oncology.

Dr. William Scoggins, chairman of the department of obstetrics and gynecology at the Medical College of

Georgia, spoke to the group on "Endotoxic or Septic Shock." He was introduced by Dr. Gordon Jackson of Macon.

Members of the **Muscogee County Medical Society** were guests of the medical staff of the Martin Army Hospital at the Main Officers Club, Fort Benning, Georgia on Tuesday, September 27, 1966.

Guest speaker for the evening was Col. Hal B. Jennings, Commanding Officer of Martin Army Hospital whose topic was "General Plastic Surgery Problems." Col. Jennings illustrated his presentation with slides showing recent advances in plastic problems particularly with Viet Nam casualties.

The Muscogee County Medical Society endorsed the establishment of a local chapter of the United Ostomy Association in Columbus with physician advisors Drs. Bill Love, A. B. Conger and Harry Brill.

**Seventh District Medical Society** was the guest of **Cobb County Medical Society** September 21, 1966, at the Marietta Country Club. A scientific program and panel discussion followed the business meeting. Robert T. Sessions, M.D. and Donald R. Rooney, M.D., Marietta, presented a paper on, "Vascular Surgery in a Community Hospital," and Maurice S. Rawlings, M.D. of Chattanooga, Tennessee, presented a paper on, "Medical Management of Myocardial Infarction."

## PERSONALS

### First District

**Curtis G. Hames** of Claxton was awarded the Georgia Heart Association's Bronze Distinguished Service Medallion in the opening session of the Georgia Heart Association's Scientific Sessions held at Jekyll Island, September 19, 1966.

### Second District

About 300 friends of **Leonard W. Willis, Sr.**, Bainbridge, met August 20, 1966, to give Dr. Willis a surprise testimonial dinner. The occasion was his 75th birthday and also the week he began the practice of medicine in Bainbridge 50 years ago. The dinner was a complete surprise to the guest of honor. Former Governor Marvin Griffin served as Master of Ceremonies, and for the benefit of the guest of honor, stated the purpose of the dinner.

### Third District

**A. B. Conger**, Columbus surgeon, was guest speaker at the Columbus Ministerial Alliance. He spoke on, "The Minister and His Health."

**Jack Hirsch** attended a course on, "Recent Advances in Internal Medicine," in Boston, October 3-7, 1966.

### Fourth District

**Thomas C. Graham**, specialist in OB-GYN and endocrinology, has joined the staff of the Papp Clinic



## THE ASSOCIATION/Continued

at Newnan. Other members of the Papp Clinic are **Joseph W. Parks**, **James H. Arnold**, **Jack W. Powell**, **Ernest E. Proctor** and **W. Earnest Barron, Jr.**

**Dr. and Mrs. R. M. Avery** celebrated their golden wedding anniversary in late September. Approximately 200 guests attended including their four children and their families and seven members of the original wedding party.

### Fifth District

**Timothy Harden, Jr.**, Decatur, has been named district chairman of the United Appeal's DeKalb County Medical Division.

**J. Gordon Barrow** of Atlanta has received the Georgia Heart Association's Silver Distinguished Service Medallion for "his long-term leadership in the fight against heart disease."

**J. Donald Fite** became associated with the Emory University School of Medicine and a member of the Emory University Clinic on July 1, 1966, immediately following a year of special study in neuro-ophthalmology as Fellow with Dr. Frank B. Walsh, Wilmer Ophthalmological Institute, Johns Hopkins Hospital, Baltimore.

On September 26, 1966, **Robert I. Lowenberg** took over the scientific portion of the program of the monthly meeting of the medical staff of the Holy Family Hospital. The presentation was on, "Lumbar Sympathectomy, Its Present-Day Indications and Limitations"; the address was illustrated with slides.

The "**R. C. Williams**, M.D. Honor Award" was recently established at Georgia State College in Atlanta to be awarded to the graduate student in hospital administration who is chosen by the faculty of Georgia State College as having manifested outstanding ability in the graduate study of hospital administration.

**Dr. R. C. Williams** was one of the persons who stimulated the establishment of a course of instruction in hospital administration in 1952 at Georgia State College. This instruction was conducted at the undergraduate level until 1965.

**Robert M. Fine**, Decatur, attended the Advanced Seminars in Dermatology held August 17-21, 1966, at the University of California Residential Conference Center, Lake Arrowhead, Calif.

**Lester Rumble, Jr.**, Atlanta, was guest speaker at the annual meeting of the North Carolina Association of Anesthesiologists in Winston-Salem on September 11, 1966.

**Richard E. Felder** recently attended the Fourth World Congress of Psychiatry in Madrid, and the Third International Congress of Psychosomatic Medicine in Paris.

### Seventh District

Recently elected Vice-President of the Carroll County unit of the Cancer Society was **T. E. Reeve** of Carrollton.

**M. D. Pittard**, member of the Toccoa Clinic, spoke as a guest faculty participant at a recent medical meeting at the Medical College of Georgia, Augusta, on August 25, 1966. The meeting was concerned with "Psychiatry in Clinical Practice" and included many topics related to this subject. Dr. Pittard's presentation consisted of a discussion from the private physician's point of view of a paper entitled "The Initial Interview as a Therapeutic Process" by Dr. M. B. Sell, Assistant Professor of Psychiatry, Medical College of Georgia.

### Tenth District

**Corbett H. Thigpen**, Augusta psychiatrist, spoke to the Savannah Rotary Club, September 12, 1966.

**George McInnes**, Augusta, has just returned from a six-month long tour of duty as the head of a surgical team in Da Nang, Viet Nam. Dr. McInnes went to Viet Nam as a volunteer under the auspices of Agency for International Development (AID), and served in a hospital that treated only Vietnamese civilians.

**Perry P. Volpitto** of Augusta was a guest speaker at the fall meeting of the Georgia Society of Anesthesiologists held in September at Augusta. His topic was, "Care, Feeding and Nurture of the Embryonic Anesthesiologist."

## 1966 CALENDAR OF MEETINGS

November 17-18—Obstetrics and Gynecology Seminar sponsored by the College of Medicine, University of Florida, Gainesville, Fla.

November 28-December 1—Third Annual Postgraduate Course on Pulmonary Function in Health and Disease, sponsored by the American Thoracic Society, the Louisiana Thoracic Society, the Tulane University School of Medicine, the Louisiana State University School of Medicine, and the Alton Ochsner Medical Foundation; Auditorium, Tulane University School of Medicine, New Orleans, La.

December 2-3—A Symposium dealing with Intracranial Vascular Surgery sponsored by Emory University School of Medicine, Emory University Hospital Auditorium, Atlanta.

December 8-9—"Pediatrics," sponsored by the Medical College of Georgia, Dept. of Continuing Education, Augusta.

January 27, 1967—Vincristine Symposium, "Current concepts of biological, pharmacological and biochemical

action, and comprehensive summaries of therapeutic results obtained in treating solid tumors and the leukemias," sponsored by the Pediatric Division of the Southwest Cancer Chemotherapy Study Group, St. Jude Children's Hospital, Memphis, Tenn.

April 30-May 1-2, 1967—113th Annual Session of the Medical Association of Georgia, Marriott Motor Hotel, Atlanta.

### Regional

December 2-4—"Initial Emergency Care and Transportation of the Sick and Injured," Program of 3-Day Course for Ambulance Attendants, Firemen, Policemen and others, Bayfront Auditorium, Miami, Fla.

### National

November 27-30—American Medical Association (Clinical Convention), Las Vegas, Nev.

January 8-10, 1967—First Annual Clinical Meeting of the Society for Cryo-Ophthalmology, Dunes Hotel, Las Vegas, Nev.



# RÉSUMÉ OF THE ACTIONS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL PHONE-CALL CONFERENCE MEETING, SEPTEMBER 2, 1966

*This report covers a phone-call Conference Meeting and is not intended as a detailed record in lieu of meeting minutes.*

**Lease of Space in MAG Headquarters Office Building** per a proposed contract with the State Department of Family and Children Services was discussed on the basis certain stipulations made by Executive Committee at its August 28, 1966, meeting. While it was generally agreed that these stipulations could be "worked out" with the Department, certain members of Executive Committee presented their sentiments about making this same space available to the Regional Medical Heart Disease, Cancer and Stroke program.

After further discussion of this matter, the Executive Committee voted to inform the Department with regret that the leasing of space be turned down—as the Association may have other use for this same space in connection with the Regional Medical Heart Disease, Cancer and Stroke program. The Executive Committee further recommended that the Association proceed to move toward becoming fiscally responsible as Applicant for the Regional Medical Heart Disease, Cancer and Stroke program.

## HIGHLIGHTS OF THE ACTIONS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING, SEPTEMBER 24, 1966, SEA ISLAND

*This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.*

**MAG Foundation** status report was given which included a review of the objectives of Foundations established by some other State Medical Associations. It was recommended to Council to proceed with the establishment of a Foundation for education and research purposes.

**Child Abuse Forms**, to be used by the Department of Family and Children Services in its child abuse reporting program were received and approved. It was explained that these forms are not to be filled out by physicians, but rather by FACS officials. It was recommended that materials on this program previously contemplated to be sent only to pediatricians, internists and general practitioners should be sent to all physicians. Reporting of suspected cases of child abuse at the hands of parents and guardians by physicians is compulsory under Georgia law.

**Georgia Hospital Association** request for endorsement of legislation to expand Board to include GHA member was disapproved on basis that Board is currently big enough, that liaison between Board and hospitals

now exists, and the possibility of an unfavorable composition of the Board may result if opened up to legislative amendment.

**Title XIX**, under Medicare was discussed and it was recommended that Council be advised of Executive Committee's desire to appoint a Title XIX study committee, with actual appointments to be made at the October meeting.

**Nominees to AMA Councils and Committees** were discussed and a Committee consisting of the three Presidents plus the Speaker of the House was appointed to review names to be submitted for possible appointment to such AMA Committees, Councils, etc.

**MAG—Family and Children Services Department** contract to review Adult Recipients claims is to be continued. This was received for information.

**Project Hope** request for appointment of a physician to its Southeast area advisory committee was received and an appointment was made.

**MAG Woman's Auxiliary** request for funds was received and it was voted to recommend to the Finance Committee that funds to finance certain out-of-state expenses for the Auxiliary President and President-Elect to one AMA Auxiliary meeting per year be allocated.

## HIGHLIGHTS OF THE ACTIONS OF THE MAG COUNCIL MEETING, SEPTEMBER 24-25, 1966

*This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.*

**Heart Disease, Cancer and Stroke**, regional medical program, with MAG to apply to the Department of H.E.W. as grant applicant and the appointment of Dr. J. W. Chambers, LaGrange, as Program Coordinator was approved. As grant applicant, MAG in cooperation with the Medical College of Georgia, Emory University School of Medicine and other organizations would receive and disburse all funds and certify the use of research and education monies to be within the scope of the program. The initial grant would finance a two and a half year study of ways and means to accomplish the objectives of the program.

**Establishment of MAG Foundation**, for education and research was given the "green light" subject to final approval of the structure, purpose and policies of the Foundation by the Council. The Foundation would serve as a repository for tax deductible monies with which to finance MAG approved Foundation projects. In the same action Legal Counsel was instructed to proceed with a working draft of all necessary Foundation papers and make a report at the December Council meeting.

**State Drug Vendor Program**, under which the Department of Family and Children Services would finance out-patient prescription drugs from a prepared formulary to welfare recipients was discussed. The program in its current status was neither approved nor disapproved by Council. Feeling that improvements might



## HIGHLIGHTS OF MEETINGS / Cont.

be possible, Council approved a three member Committee consisting of Linton Bishop, Chairman; Floyd Sanders and Fleming Jolley to study and make recommendations at the October Executive Committee meeting.

**Title XIX, Public Law 89-97**, that portion of the Medicare Act which affords the potential for vast extensions of medical, hospital and other aspects of health care to welfare recipients was discussed. An Ad Hoc Committee to study all phases of Title XIX and to compile all data needed by MAG to make an effective evaluation of this program was approved. Executive Committee was designated to appoint this Committee.

**MAG Legislative Report** was approved asking the State Pharmacy Board to declare LSD as a dangerous drug thereby subjecting it to the same restrictions and controls in force on other dangerous drugs; and designation of a Committee to consult with representatives of industry and the Workman's Compensation Board in an effort to increase the statutory limits of \$2,500 on medical fees payable under Workman's Compensation Insurance.

**Board of Health Legislative Program**, discussed by the Board's Legislative Committee Chairman, was received for information in keeping with the established policy of improving liaison between MAG and the Board of Health at all levels of activity.

**Joint Commission on Accreditation** of Hospital, Bulletin 41, on functions of "hospital utilization committees" were discussed in connection with a Georgia Medical Society (Chatham) resolution asserting that these regulations had become too extensive, too time consuming and bordered on interference with medical practice. The resolution called for certain limitations to JCAH regulations. The matter was referred to the Hospital Activities Committee for additional study.

**An AMA House of Delegates** resolution relating to ethical conduct on the part of a physician employed by a hospital for the purpose of displacing a fellow physician then engaged in a dispute with said hospital, and the subsequent non-implementation of the resolution by the AMA Board of Trustees for legal reasons was discussed. MAG representatives to the AMA House of Delegates were instructed to uphold the AMA Board of Trustees when this matter is reintroduced, probably at the November Clinical Convention.

**Medical College of Georgia Circuit Courses**, co-sponsored by MAG received continuing approval with commendation and it was directed that publicity on these courses be carried in the *Journal of MAG*.

**1966 MAG House of Delegates Actions**, were discussed and it was reported that of the 71 total House actions, 49 had been completed, ten (10) were in progress toward completion and 12 were yet to be undertaken.

**Joint MAG and U.S. Treasury Department Anti-Moonshine** campaign to advertise by billboards and car cards that "Moonshine Kills" was reviewed and received for information. This campaign was undertaken by MAG because of the health hazards imposed by lead salts poisoning in moonshine whiskey.

## HIGHLIGHTS OF THE ACTIONS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING, OCTOBER 23, 1966, ATLANTA

*This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.*

**Military Medicare Program Expansion** report was approved by Executive Committee for MAG as contractor with the Office of Dependents' Medical Care. This expansion, enacted by Congress on September 30, 1966, becomes effective in two phases:

October 1, 1966—Care for the present dependents of active duty personnel in the Armed Forces expanded to include "outpatient services by physicians" on the basis of usual, customary and reasonable charges, diagnostic tests and procedures, physical therapy, prescription drugs, etc. MAG will send a full explanation of the expanded benefits under this program to all physicians within the next two weeks. Outpatient care will be subject to an annual deductible of \$50.00 per dependent or \$100.00 per family plus 20% of the charges for the authorized outpatient services in excess of the annual deductible payable by the patient.

January 1, 1967—Number of eligible dependents increased to include those dependents of retired Armed Forces personnel.

**Hospital Based Physician Resolution No. 1** on ethics involved in percentage contracts as passed by 1966 MAG House of Delegates was discussed by MAG Delegates to AMA pertinent to MAG Council action which asked that a similar resolution be introduced at AMA level. Because of new information on this matter, Executive Committee voted to re-refer this item to the MAG Council at their December 10, 1966, meeting for future consideration. MAG Delegates to AMA were requested to hold this matter in abeyance until Council could be apprised of this new information.

**Study Committee on Title 19** was appointed in an effort to become more cognizant of the complexities of this law in behalf of MAG. Title 19 provides for an extension of the present Kerr-Mills (Adult Recipient's Program) benefits as administered by the State Department of Family and Children Services. Georgia has not yet implemented Title 19, but all states must implement this program by 1970.

**MAG Headquarters Office Building Expansion** Study Committee was appointed to investigate Association needs for additional office space. This committee was instructed to consider long-range plans for the increasing activities of the Association and report to MAG at some future date.

**Other Items** acted on by Executive Committee included appointment of MAG Representatives to "Project Hope"; approval of an interim report by the MAG Auto Traffic Safety Committee; approval of booth space for the Treasury Department Bureau of Narcotics at the 1967 Annual Session; and approval of financial assistance to an MAG member in accord with the MAG-County Medical Society matching pension fund provisions.

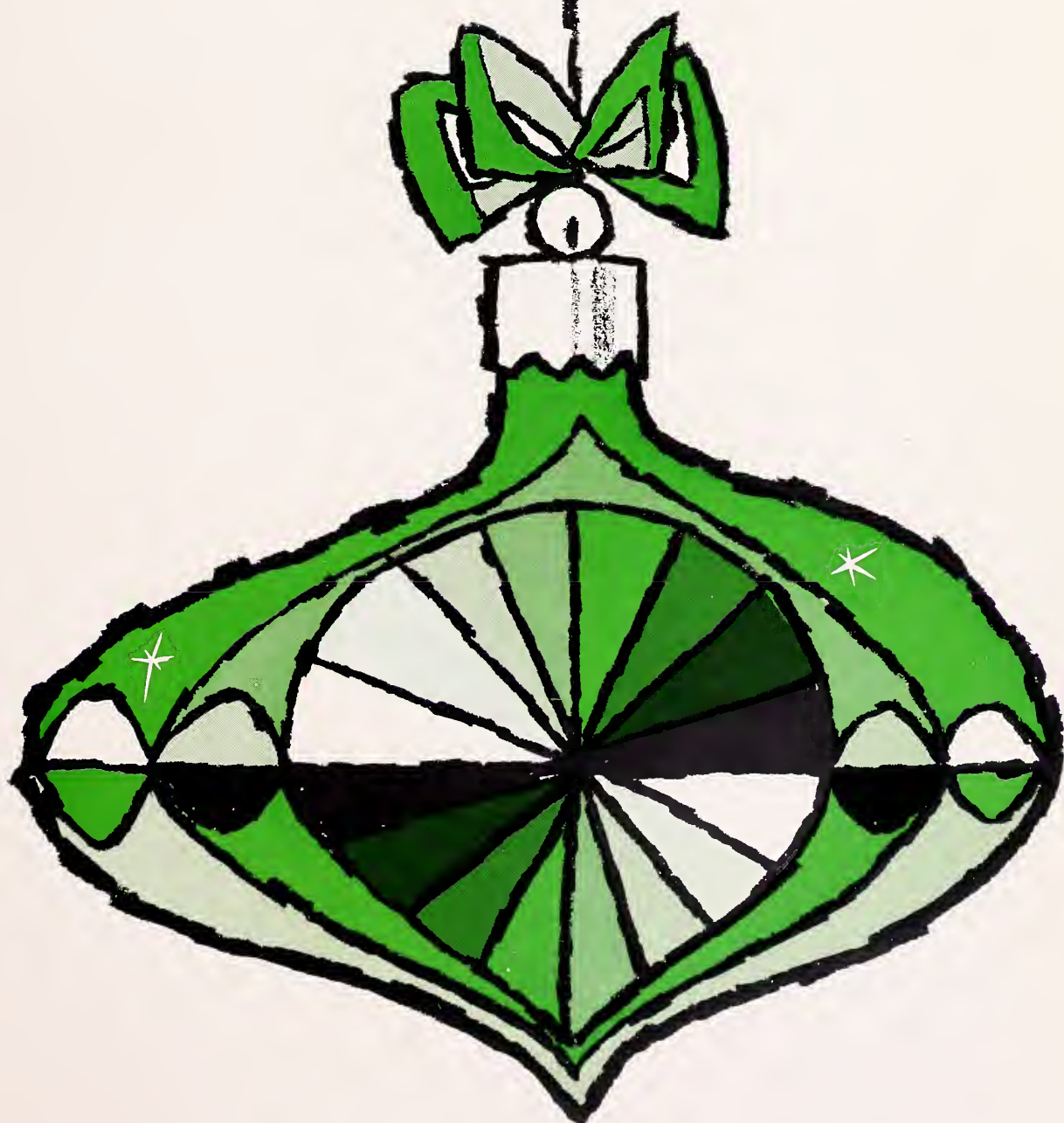
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# Georgia

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### Cover

Design by John Watt, Atlanta



only one in the morning 

and one in the evening 



# A DESCRIPTION OF THE HIGH RISK PREGNANCY PROJECT AT GRADY MEMORIAL HOSPITAL

W. Newton Long, M.D., *Atlanta*

- Since maternal mortality and morbidity have been reduced, more attention is directed toward the safety and health of the unborn and recently born baby.

FOR SEVERAL REASONS I am fortunate to be talking to you today, and I would like to tell you about one of them. In 1918 I was a home delivery. My mother was a 28-year-old Para 1 with no living children. My older brother was delivered by high forceps, and in the process of delivery, the head became disengaged from the body. It is my understanding that my father consulted the family doctor about one month before the expected date of delivery of your speaker, and as far as I can determine, this is the prenatal care that my mother received. Had she had a postpartum hemorrhage requiring transfusion, the nearest typing sera was in a city 72 miles away approximately three hours by rail. The local county hospital delivered two or three babies a month, mostly to women who had no home. In that year the maternal mortality rate was 82 per 10,000 live births<sup>1</sup> among white women and the perinatal mortality rate among the same group was apparently in excess of 140.<sup>2, 3, 4</sup> Probably the chief concern of obstetricians that year was the great influenza epidemic which apparently exceeded hemorrhage, toxemia, and sepsis in producing maternal disaster. This was the year in which undertakers sold many white caskets and the small white hearse was seen on the streets of our town well into my memory much more frequently than the big black one.

My first child was born five months after V-J Day in 1946 in a large obstetrical hospital following at least ten prenatal visits. Compatible blood was always available. The effect of analgesia and anesthesia was pretty well understood and respected. The obstetrician was a man of long training and great ability and judgment.

By the time my daughter was born the perinatal mortality rate was 24 and it gradually declined to approximately 20 in 1958. Since then it has risen slightly.

## In One Generation

This narrative serves the purpose of highlighting the fact that in one generation the practice of obstetrics together with the care of the newborn infant has changed more than in the entire span of recorded history prior to this time. The maternal mortality rate has been reduced to one-tenth of its previous incidence to the point that actually the death rate among pregnant women is lower than that among non-pregnant women for the same age. We all know the factors associated with this—better trained obstetricians, better identification of medical complications, available blood for blood transfusions, improved anesthesia for delivery, antibiotics for control of infection, and the now almost universal use of hospitals for management of labor and delivery. Not an inconsiderable factor in improved maternal statistics was the establishment of maternal mortality committees in large cities charged with the responsibility of examining in detail the histories and management of cases of maternal deaths. If a degree of physician or hospital responsibility was involved, notification of this fact was made and what prior to 1930 was often thought to be a regrettable but unavoidable occurrence became a departmental tragedy.

## Major Focus

The major focus upon perinatal mortality and morbidity began in the late 1940's, stimulated by the fact that obstetricians no longer could measure the excellence of their practice by maternal results and by the fact that the declining perinatal mortality

Presented at the 112th Annual Session of the Medical Association of Georgia, May 9, 1966, Columbus, Georgia.



## **PREGNANCY PROJECT AT GRADY / Long**

had begun to level off during the 1940's. Drs. Edith Potter, George Anderson, and Alexander Shaffer brought this concern to a head by elucidating a great amount of information with regard to the pathology of the fetus and the newborn infant. Prior to this time there had, of course, been a good deal of information and concern about the fetus. As early as 1920 health officers had recognized that perinatal mortality was much higher among poor people than among the well-to-do people, but even here the major emphasis was on the prevention of infection between the ages of one month and one year.

The Children's Bureau nationally and the Atlanta community locally is concerned, of course, not only with the number of infant deaths but the number of infants born alive who are handicapped by a variety of birth defects. That this is a growing problem needs no elaboration, save to remind ourselves that the increase is due to the increase in the total number of births, as well as the increase of survival of defective children who a generation or so ago would have died in the process of birth or in the neonatal period. The cost in terms of dollars of babies with major birth defects, both locally and nationally, is rather staggering. Depending upon whom you read, it costs between \$40,000 and \$100,000 to care for a mentally retarded child from the time of birth until the time of death. It is a safe estimate that there are about 600 such babies born in Atlanta every year. The cost in terms of crime, draft rejection, special educational facilities, control of juvenile delinquency, is above and beyond the \$24,000,000 estimate, and the heartbreak to parents, relatives, and friends is incalculable.

### **A Significant Reduction**

The Grady Project, funded by Children's Bureau and local matching funds, aims to reduce the incidence significantly in Atlanta of mental retardates. This will be done by reducing the incidence of prematurity in the Grady population as well as by prevention of pregnancies among those most likely genetically to produce dead or damaged infants.

Grady Hospital delivers about 7,000 patients a year, or approximately one-third of the deliveries in metropolitan Atlanta. Its patients are almost exclusively from the medically indigent group, those most likely to have premature and damaged infants.

The Project application was approved in March, 1965, and became operational around July 1, 1965. Its personnel includes a Project Director, a Pediatric Project Director, an Assistant Project Director, an Administrative Assistant, six Liaison Nurses, a Nutritionist, a Social Worker, a Nursing Instructor, a Clinic Coordinator, Statistician, Finance Officer,

Staff Nurses, and Clerks. I thought you would be interested in the functioning of the Project to this time, and for the purpose of clarity will try to illustrate by typical case history.

### **Likelihood of Difficulty**

Any woman in Atlanta so desiring may make an appointment with the Prenatal Clinic, at which time she is screened from the standpoint of her likelihood of obstetric or neonatal difficulty. If she has hematologic, cardiac, hypertensive, pulmonary, pelvic, renal, or psychiatric problems of significant degree, she is classified as being at high risk. She will therefore receive the balance of her prenatal care, medications, labor and delivery care, and postpartum care from funds appropriated for this purpose. If she does not so qualify, and if she is Grady eligible, she will be referred to a County Health Clinic for continuance of prenatal care and will return to Grady for delivery. If she is not Grady eligible, she must seek her obstetric care elsewhere. If in the course of a hitherto normal pregnancy, an unanticipated problem arises such as lobar pneumonia, elevation of blood pressure, or development of intercurrent anemia, or vaginal bleeding, she may be referred back to Grady Hospital where her degree of illness is estimated, and if pathology is verified she is secondarily classified as being at high risk. In either case, the high risk patient is then followed through the remainder of her pregnancy in one of several special outpatient clinics managed by senior clinicians, all members of the faculty of Emory University School of Medicine. The senior clinician evaluates the disease process and dictates a short note outlining his diagnostic studies and sets forth a plan for the remainder of her pregnancy and the conduct of her delivery. Thereafter, she will be followed in the same clinic area, usually by members of the Grady Hospital House Staff. The senior clinician is always available, however, for reconsultation regarding these patients and is physically present in the clinic at the time his patients are seen.

### **Available Help**

As alluded to above, Liaison Nurses, Social Workers, and Nutritionists are available for help in solving problems unique to their field. Classes for mothers, audiovisual educational material, and discussion groups aid the patient in understanding her problems, and give opportunity for discussion with others, taking away to a large degree the fear that the woman has about herself and her unborn infant.

Twenty-five beds are available for diagnostic study and therapy of the antepartum patient as needed. Following delivery the patient is returned to another 25-bed area, and frequently it is necessary to



TABLE I  
GROSS STATISTICS  
JULY 1, 1965-FEBRUARY 28, 1966

	Unregistered	High Risk	Normal	Combined
Deliveries				
No. ....	913	926	2936	4475
Per Cent ....	20.4	20.7%*	58.9	100.0
Perinatal Deaths				
No. ....	65	36	67	168
Rate Per 1,000 ....	81.6	45.3	27.7	41.9
Prematurity				
No. ....	206	155	326	687
Rate Per 1,000 ....	225.6	167.3	123.7	153.5

\* % High Risk of Patients Seeking Care—25.9%.

reevaluate and to treat further the complication noted during the antepartum course. It is at this time that patients are assisted in making further plans for child-spacing or contraception, and in a small but substantial number of cases the patient is fitted with an intrauterine contraceptive device prior to going home from the hospital. At the six week return examination all patients, including the high risk patients, are offered family planning services. The Family Planning Clinic is maintained by the Emory University Family Planning Clinic operated under an independent grant, and to date some 4500 intrauterine devices have been inserted by this group.

### Only One Nonmaternal Death

Up to this time, with data from July 1, 1965, to February 28, 1966, there has been one adult nonmaternal death among the mothers. This patient died of metastatic carcinoma of the liver about one month after her delivery. The infant or neonatal results are summarized in the Table. (See Table I.) As you can see, approximately one-fifth of all the deliveries of Grady patients had been classified as being high risk. It appears from the relatively good results as expressed in the low perinatal death rate and low prematurity rate in the normal group that we are correctly identifying a high risk group. It also appears that another one-fifth of our deliveries among unregistered patients represents an area for intensive clinic recruiting because this group has the highest prematurity and perinatal death rate of all. Thirdly, it is likely but not definite that the Project work has done some good inasmuch as the total delivery figures have yielded the lowest prematurity rate we have had at Grady in the past five years and the lowest perinatal mortality rate in four years. Further breakdown of our results yields figures so far too small to be significant. They are however interesting. For example, the highest rate of prematurity originates in the fetal medicine clinic among patients who have previously delivered premature or abnormal infants and among the hypertensives. In the latter group this, of course, is understandable because all

too often premature induction of labor is needed to treat superimposed preeclampsia and because in many instances of essential hypertension, fetal growth retardation occurs.

So much for what has happened to this point. By the end of June, 1966, we should have enough cases in each complication group to have specific prematurity, mortality, and morbidity figures to tell us what disease process in the mother is associated with the highest infant risk. Nutritional studies among desperately poor women need to be made and community support in the areas of food and transportation need to be obtained. Women with strong medical and genetic reasons for avoidance of pregnancy should be offered tubal sterilization, and I should estimate that we should be doing about ten times as many sterilizations as we are now able to carry out.

In general, I reasonably expect by the end of five years, the projected duration of the program, to have seen substantial further reduction in prematurity and therefore in mentally retarded and damaged children among those delivered at Grady Hospital. I expect to see greater effective use of family planning, particularly among women with poor reproductive histories, and finally, I expect to see a great body of retrievable obstetric and pediatric data, the study of which will shed a little bit more light on the question we all ask—"How to have fewer and better babies?"

### Summary

In summary, as maternal mortality and morbidity has declined, physicians have become more and more concerned about the safety and health of the unborn and recently born baby. For many indigent women pregnancy is the only time medical care is sought, and in one-fifth of all the Grady population, significant degrees of medical or obstetric complication exist. By attention to and/or correction of these complications it appears that real inroads have been made into the big problem of prematurity, and prematurity seems to be the largest single clinical association with mental retardation. Finally, any program designed to improve infant results must concern itself with avoidance and spacing of pregnancies, particularly in indigent population groups.

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# FREEDOM—THE WAVE OF THE FUTURE

Charles L. Hudson, M.D., *Chicago*  
*President, American Medical Association*

IF I DIDN'T KNOW BETTER—at least, I think I know better—it would be reasonable for me to assume that I have an enemy on the planning committee for this Public Relations Institute.

You people have been here for a day and a half. Much of that time you have spent listening to speeches—all of which, by the way, I will say were excellent, well planned and well aimed at the purposes of this conference.

This is the final session. As of this moment, you are tired; you have been extremely well fed; you have your return ticket in your pocket; and you probably are thinking seriously about the amount of work waiting for you at home.

So now they let me talk.

## A Considered Challenge

I consider it a real challenge and I'll do my best to face up to it. I must say, however, that I feel about like a commencement speaker at a college graduation. Everybody is too polite to walk out on me, but they're really wishing I would sit down so they could be on their way to wherever they're going.

With due regard to the clock on the wall, I do want to give you a few of my thoughts that I hope you will take home with you.

I want to begin by referring to Dr. Blasingame's opening remarks yesterday morning in order to assure you of my complete agreement that this is very likely the most important Public Relations Institute the American Medical Association has held in recent years.

If our association, and American medicine which we represent, has ever faced a period of crisis—or, if you prefer, of challenge—this certainly is such a period.

For the past several years—at this conference; at the annual and clinical conventions; and at other medical meetings—we have been concerned with something that appeared to be over the horizon. Now we have reached the horizon toward which we were pointing through those years. Medicare is no longer

only a promise or a threat. It has become a fact. It is the law of the land.

The people who have tried for such a long time to institute government-paid health service for all of the citizens of our country have attained their first victory.

To be sure, they do not yet have all that they want; nor even a large portion of it. But they have taken the first step toward their comprehensive goal.

There is, in existence today, a program of the kind that organized medicine resisted successfully for more than 30 years; a program which provides federal payment for health care given to people without regard to need, or to any qualification other than the attainment of a specified age.

## No Easy Path

The easiest path to take in talking about this subject is to wail that all is lost; to paint dreary pictures of a hopeless future. As a matter of fact, the easiest thing for us to do, as organized medicine, probably is to sit down in defeat and give up, saying to ourselves that we have fought a losing battle and that we would be wasting our time to continue our opposition to what now appears to be the wave of the future—socialism; or, to use a less offensive term, the welfare state.

But I'm not going to take that easiest route as a speaker. Nor do I believe any of us seriously wants to take the easy road in our personal and professional lives.

For better or worse, I am an incurable optimist. I believe that the welfare state is not necessarily the wave of the future. Quite to the contrary, I believe that the wave of the future for the United States can be more freedom; a more vital free enterprise; and a more energetic individual initiative.

But that happy prediction is not going to come true all by itself. It's going to have to be made to come true. And making that happen is going to take a great deal of work and an inspiring amount of devotion to the cause of what we call freedom.

I worded that last statement carefully: "the cause of what we call freedom."

I don't believe that when we use the word "freedom" we are contrasting it to out-and-out slavery. Instead, we use it in the context of a way of life that is opposed to the philosophy of government direction or government interference in affairs that we consider strictly private, and which were once strictly private in this nation.

The mistake many conservatives make—and this includes people not only in the field of medicine, but in other professions, in business and in politics itself—is that we forget the kind of audience to which we are speaking.

### About Ancient History

We talk glibly of the catastrophe usually referred to as "The Great Depression," and criticize the direction our federal government has taken since those days, as though our audiences knew what we were talking about. The thing we forget is that we are not talking about things these people experienced, but are discussing things millions have only studied in school. To say to the American public today that we should return to a form of government or form of free economy that was prevalent before the New Deal is the same as recommending that we return to the days of the Greek city-states or the Renaissance. We're talking about ancient history.

Forty-six out of every 100 Americans today are under 25 years of age. That means they were born in 1941 or after. Only a few of them have a vague, childhood memory of the end of World War II. The post war inflationary period was their elementary school days. Another 25 out of every 100 are fewer than 45 years old. They were born in 1921 or later. Many of them have memories from their early teens of the depression. Perhaps these memories are of poverty and suffering in the family, if their father was among the several million unemployed. But they don't remember anything of significance before the depression.

All of these people—totaling 71 out of every 100 in this country—grew up in a world that was different from the one in which the older ones of us were reared. Their attitudes were shaped by different forces. Their view of the proper place for government in our lives is entirely different.

For example, we are genuinely concerned about government interference in so many phases of our lives today. But put yourself in the shoes of these young people.

They hardly considered it interference for the GI Bill to pay the tuition and fees for their college education after World War II. Without that help, many of them might not have been able to go to college.

They hardly consider it interference that the government provides their children with a free hot lunch in school.

They hardly considered it interference that the government guaranteed the loan for their house, enabling them to buy a nice home with no down payment when they came out of military service.

They probably did not consider it unjustified interference when the steel or copper or aluminum industry raised its prices and the President of the United States forced the cancellation of increase. I'm sure it was generally agreed that it was about time somebody did something about rising prices.

They are not likely to consider it interference if the government sets standards for product packaging in an avowed effort to stop big business from cheating the poor housewife.

And with the background these people have developed in their lives, I'm sure they won't consider it interference if the government saves them some money by paying a share of the cost the next time their aging mother or father has to go to the hospital or undergo a series of treatments by a physician.

### To Win Support

No matter how strongly we might feel about these things, we aren't going to be able to turn back the clock. We're also not going to make points with many people by criticizing the government for the things it has done and is doing. Nobody can win support by knocking Santa Claus.

There are too many people who favor everything the government does, and who have been trained and molded since childhood to expect the government to do more. They expect it, because they have been conditioned for 30 years to accept the fact that only the government is capable enough or—here is where the real indictment of the private sector comes in—interested enough to solve the problems that need solving.

In too many instances, this has just about been true. Unfortunately, when the world suddenly turned over and this country was plunged into depression, some of the people who were the bulwarks of free enterprise refused to bend, and refused to see that the time had come for free enterprise to adapt itself to the needs of society to a larger extent than it had done before.

If we and our brethren in business, industry, other professions and the conservative side of politics are to be successful in preserving and re-vitalizing free enterprise in this country in the years ahead, I think our argument should not be that the government shouldn't do this; or that the government has no right to do that; or that the government is eroding our freedom by doing the other. Instead, our argument—backed with demonstrated proof—should be that there is no need for the government to do it, because it is being done so well by the private sector.



This, I sincerely believe, is an approach that the people will accept and believe. Traditionally, from the New Deal through the Fair Deal and the New Frontier into the Great Society, people have called on the government to do things they felt were not being done by anybody else.

In many cases, of course, the people themselves did not notice that nothing was being done. The government discovered and announced the need; and at the same time announced its proposed solution. And the people agreed with enthusiasm.

If all of us in the private sectors of our economy can effectively eliminate the apparent need for government involvement, I believe we can win our point with the public. I don't believe the people are yet ready to stand by and see the government force itself into fields where it is not needed.

For example, government has persuaded people that many producers are cheating them with oversized packages, misleading illustrations on boxes and confusing prices. A few examples have been proved.

In the case of one product, the regular size package might cost 35 cents and contain 5 $\frac{3}{8}$  ounces. The giant economy package is 88 cents, but holds 12 $\frac{1}{2}$  ounces. It is unlikely that many housewives can apply a slide rule to the boxes and determine that the regular size costs 6 $\frac{1}{4}$  cents per ounce, whereas the large package is 6 $\frac{7}{8}$  cents—a higher unit cost.

If business is going to convince the public there is no need for government control or direction of packaging, labeling and pricing, it is going to have to make sure instances such as that one no longer exist.

In the larger picture of our economy and the welfare of our people, business leaders point out continually that the true path to progress and jobs and the creation of wealth is the expansion of business and industry and the attraction of additional investment money. That's true. But business is going to have to do more than talk about it.

### **Prove by Doing**

Business and industry are going to have to prove to the carefully watching public that they can create jobs, and can eliminate poverty, by doing it. Otherwise, the people are going to continue to demand that the federal government do it with anti-poverty programs and government-sponsored training courses for people who are unable to get jobs.

We are in exactly this same position.

Our involvement with government at all levels, of course, as a medical profession, is long-standing. The many ways in which we have worked with both civilian and military agencies are so well known and

so basically established that I feel perfectly justified in ignoring them for our purposes today.

It is the new program, medicare, which must concern us. And our concern is not primarily with the program as it stands now, but with the implications it perhaps carries for the future.

Medicare itself, as now constituted, is a program with which we can live without a great deal of difficulty. Without apologizing for it, or without seeming to have withdrawn any of my opposition to it, I can say, from an objective standpoint, that it is not an indigestible pill.

It does not, at present, limit the patient's choice of a physician. Nor does it restrict the physician's choice of treatment. We are clearly privileged to make our own choice regarding participation in the financial aspects of medicare. We can accept assignment and seek reimbursement from the carrier; or, as the consensus has indicated we prefer, we can deal only with our patient, as in the past, allowing him, in turn, to be reimbursed by the fiscal carrier.

### **Not Provisions But Implications**

I think it is worth repeating that the principal threat of medicare is not its provisions, but its implications.

Does it, as some of its proponents have said, in apparent sincerity, represent a goal in itself? Or, as seems more likely from the statements of other persons, both inside and outside of government, does it represent only that first step toward total governmental responsibility for medical care—either its financial aspects or its complete direction and control?

For the security of our patients and of our profession, we must assume that the latter is true. We must assume that further "need"—and I put quotation marks around "need"—for government involvement in medicine will be pointed out by political leaders and their social-minded supporters; and that additional, more inclusive, more restrictive programs will be proposed to meet those needs. We can further assume that the public, for the most part, will again accept both the government's analysis of the need and its recommendations for solution.

The public will accept the government's contentions, that is, unless we are able to make it obvious that no such need exists for further government involvement.

There is probably no action we can take that would preclude further proposals by the government with respect to so-called social insurance involving medical care. Our behavior, therefore, must be pinned to the hope that we can make such a showing before the public that when paternalistic proposals are made, they will not be immediately endorsed and embraced.

We have a tremendous opportunity to make that showing.

It is estimated that physicians see 2,100,000 patients every day, on the average. That means, beginning tomorrow, that by November 26, counting repeat visits, we shall see a number of people equivalent to the total population of the United States. We see that total number four times a year.

From the standpoint of dealing directly with people, that is a much better opportunity than the politicians have. Keeping in mind the famous admonition that "What you are thunders so loudly that I cannot hear what you say," we should be able to do a job with our patients that will outweigh anything somebody else tells them about the way we do it.

If that is to be true, however, it means we must do a genuinely good job.

### **A Demonstration of Competence**

We must clearly demonstrate our competence to carry out all of the technical, professional and administrative responsibilities which naturally devolve upon us as individual physicians and as the medical profession of this country.

We must undertake and assiduously carry out a program of careful and critical self-examination. Such a program does not imply an indictment of our profession or of its members. It is not designed to develop criticism, but rather is to prevent criticism from others by enabling us to spot our own weak points, wherever they exist, and to correct them ourselves. Such a policy is common to virtually all successful enterprises with the probable exception of government, and it certainly should be the hallmark of a profession such as ours.

I would recommend three parts for our program of self-examination and the demonstration of our professional competence.

*First* is the evaluation of the quality of service rendered by physicians and their allies in the health services field—in a hospital, in an office or in a patient's home.

This is a point I have expounded before, in my statements to the House of Delegates at the June Annual Convention of the AMA and elsewhere. But I feel so strongly about it that it bears repeating. We ought both to look closely at all of the existing

means of evaluating the quality of our service, and to develop new ones. I think it is mandatory that we not only be able to document the quality of our service in the future, but that we be able to substantiate the accuracy and excellence of our techniques of evaluation.

*Second* is the subject of manpower, another topic on which many of you have heard me speak before. We face problems of increased demand for medical services in the years ahead, because of population growth; increased longevity—which is a splendid example of our having caused at least one of our own problems; the general affluence of our society; and the effect of such programs as medicare and Title 19.

We must avoid becoming complacent because of statistics which prove that the physician population is growing faster than the total population. Instead, we must look at the entire field of medicine; determine what kinds of services will be needed; and further determine what kind of people, with what kind of skills, we must have available to meet those needs.

If present educational and training programs are not developing those people in enough quantity or high enough quality to meet the needs we can see, we must undertake to help improve and expand those programs.

And *finally*, since I feel obligated to treat each of these points only briefly, we must look for bold new approaches to the whole subject of national health care. We must offer leadership in finding problems where they exist and in developing workable solutions. If we fail to do this, we shall find ourselves in the position of constantly reacting to somebody else's proposals rather than acting upon our own.

I thank all of you for your very kind attention, and I further wish to express my personal gratitude for the contribution each of you has made to the success of this 1966 Public Relations Institute.

I believe we have seen a spirit exhibited here which clearly indicates that there are no problems faced by medicine in America that cannot be solved by the continuing and increasing cooperation of the medical brotherhood so impressively represented by this group.

Good luck to all of you.

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# SPONTANEOUS HEMORRHAGE

W. P. Rhyne, M.D., *Albany*

- An unexplained and intriguing relationship is discussed.

IN THE DIURNAL projection of physical phenomena, we are confronted, at one time or another, with recurrences that seem to follow a pattern for which there is no explanation. We have often heard, "Wait until the dark of the moon," for planting this or that; "Today would be a good day for planting turnips," "I wouldn't plow that field or cut that tree until the moon is right," "You can dig the postholes if you must, but there won't be enough dirt left out to make the post stick," or "If you are killing hogs today, heaven help! You will have all lard and very little meat."

## By Such Lore

Where do we come by such lore, and on what grounds are such statements made? Much of it is handed down from generation to generation, while some is based on hearsay and some on observation. There has been no real scientific work done in the past several centuries which would prove or disprove any of the above.

The French government did some work on the subject in 1906 but arrived at no definite conclusions and subsequently dropped the matter. The U.S. Department of Agriculture did a small amount of work in 1903 on "The Effect of the Moon on Growth of Corn," but again there were no conclusions. The department, which controls the meat packing industry, pleads *nolo contendere* to claims that the amount of lard produced at any given time varies in comparison with other times.

Mr. F. A. Anderson of Boston has given hints as to the proper time to invest in stocks. And although proven right, he doesn't know why or what underlying influence is responsible.

Plastic surgeons in ancient India delayed operating until the wane of the moon in order to get less scarring. And, I might add, that is precisely what happens.

Dr. Edson J. Andrews of Tallahassee, Florida, has observed that there is more bleeding during operations for tonsils at the time of the full moon. There are people who delay operations until "the signs are right."

What is the right sign? The reference is to the signs of the zodiac: Aries, Taurus, Gemini, etc. A

sign of the zodiac theoretically controls that part of the body to which it is ascribed, *i.e.* Aries, the head; Taurus, the neck; Gemini, the arms, and so on throughout the body. When the earth passes through the specific sign, that part of the body so ascribed will be affected or activated more than at any other time.

We have been handed this bill of goods from the ancients. There is some doubt and some evidence, but no proof that these phenomena actually exist. But what have we done with this seemingly irrelevant piece of folklore? Nothing. Apparently we are unbelievers, or we can see no real connection with our existence. The diurnal fluctuations of body fluids, blood pressure, pulse rate and other events are looked upon as natural activity. And consequently we have never gotten down to the actual precipitating causes of these varied changes.

Members of "AA" and other "wagoneers" have told me that the most crucial time for abstaining from drink is during the time of the full moon. More crimes are perpetrated during full moon than at other times. Why?

## Zodiac Variation

The fullness of the moon and the zodiac do not coincide exactly. The moon goes through its several phases in an exact amount of time, while the time intervals for the zodiac vary from 25 to 29 days. Thus the moon gains upon the zodiac almost one whole set of signs in each year. Each phase of the moon falls on a different sign each time. Therefore those happenings which have been ascribed to the influence of the full moon have accidentally fallen on a full moon coincidental with the sign of the zodiac which was most influential.

Thus we eliminate the influence of the moon from the subject of spontaneous hemorrhage and direct our attention to the signs of the zodiac. I do not presume to have the final answer, but I am submitting this material which I have gathered, believing it might throw some light on the subject.

In astronomy and astrology, a zone of the heavens within which lie the paths of the sun, moon and major planets is generally referred to as the zodiac or "Little Animal." It is bounded by two circles



## HEMORRHAGE / Rhyne

equidistant from the ecliptic and about 18 degrees apart. It is divided into 12 signs and marked by 12 constellations. These 12 constellations and signs correspond—Aries, Taurus, Gemini, Cancer, Leo, Virgo, Libra, Scorpio, Sagittarius, Capricornis, Aquarius and Pisces.

Technically the 12 signs are geometrical divisions 30 degrees in extent counting from the position of the sun at the vernal equinox. In the time of Hipparchus, the signs correspond fairly closely with the constellations. That is to say the first sign (Aries) corresponded with the constellation Aries. Because of procession there is now a discrepancy amounting to the breadth of a whole sign. Aries is now occupied by the sign Pisces. This being so, and assuming that more activity is exhibited in a given area when the sign is in that area, we proceed with the following data.

### Nasal Hemorrhage

Nasal hemorrhage, the most noticeable of the spontaneous hemorrhages, is probably the most common occurrence in the practice of medicine. Exact records are not kept generally because most hemorrhages are handled in the E.R. and records destroyed after E.R. charges are settled. Thus, time of occurrence is forgotten. Every effort is made, of course, to allay the fears of the patient and family and stop the bleeding. Usually when the bleeding is controlled, the patient goes his own way. Hospitals have very few records that supply substantial information except for prolonged bleeding episodes which require hospital care.

With a lack of hospital records, I have resorted to my own records and those of several colleagues for this study.

Reviewing more than one thousand nosebleeds since 1930, and looking particularly at the time of bleeding, we have discovered the revealing fact that in more than 90% of cases where bleeding occurred, the sign was from the knee to the foot. We also noted that when the sign was in that area, it was not unusual to have several nosebleeds to handle in a 24-hour period. The sign Pisces—from the knee to the toe—is now actually the sign of Aries—the head. If what has been handed down is true, the bleeding does take place when the sign is in the head.

All my life I have heard that certain phenomena were due to the moon or the sign of the zodiac, but no one has ever been able to give a reason. I have checked with numerous people whom I thought could be of help, but no help was found. I have asked meat packers, farmers, doctors, garbage collectors, housewives, octogenarians, centurions, literates and illiterates, but no forthright answer was

found. Even now I don't know why it occurs, but I do have a good idea when it will occur the most.

On January 24, 1947, the fifth nosebleed of the day came into my office. There had been none the week before. An occurrence of this kind would arouse very little interest except to disturb one's schedule. As everyone knows, each individual nosebleed is a separate entity, and must be dealt with accordingly. The full moon in January of 1947 was on the 6th and the new moon on the 22nd. Therefore the full moon could have had little effect on that particular date. I checked the almanac, and the sign was in Pisces—the lower leg and foot. Then I began checking back on nosebleeds and hemorrhages. I checked my own and my partner's records from 1930 forward. My primary interest was in the time of the hemorrhage as it pertained to natural phenomena—moon, sun, stars, and the signs of the zodiac. The records showed these occurrences when the sign was in Pisces with such regularity that I began checking in earnest with hospitals and doctors to see if they had had the same experiences. I found that they did!

One of my well-intentioned philosopher friends explained that when the sign is in the lower leg, it increases the pressure in the head, and bleeding results. I didn't refute the claim, but I had no way of proving or disproving it.

As I have stated before, records are hard to come by, and a statistical analysis is difficult to compile. Nosebleeds are not one of the more reportable conditions of man. They, like headaches, are handled and quickly forgotten.

I think it would be excellent to know just why this condition occurs at a particular sign of the zodiac, and I would be most appreciative if someone can throw some light on the subject.

The Roman astrologer Spurinna told Julius Caesar to "Beware the Ides of March." The same warning was in an *AMA Journal* in the spring of 1929. The article concerns the activity of gastric and duodenal ulcers with the statement that the ulcers are more prone to cause severe pain and possible bleeding during this period. I have seen no reference to that possibility since that time.

Many great things have come about in times gone by, but no one has ever checked to determine just why they happened or what was the condition of the moon and the stars when they happened.

The full moon alone has been held responsible for many of these occurrences, but in my own little section of the wheel, the worst things happen when the moon is full and the sign is in Pisces.

Remember the Watts riot on August 23, 1965? The moon was full and the sign was in Pisces.

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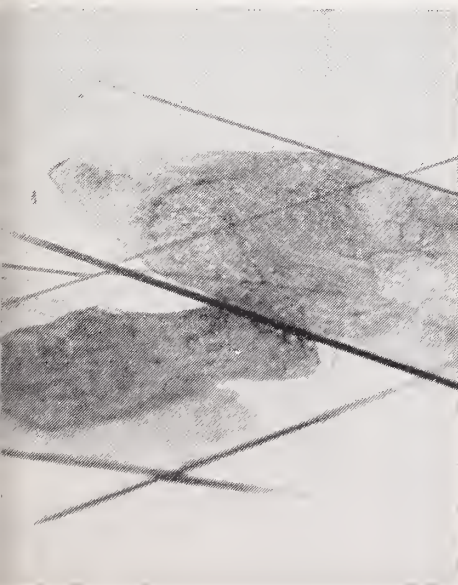
2. nonpregnant women with a history of recent  
or recurrent monilial vaginitis



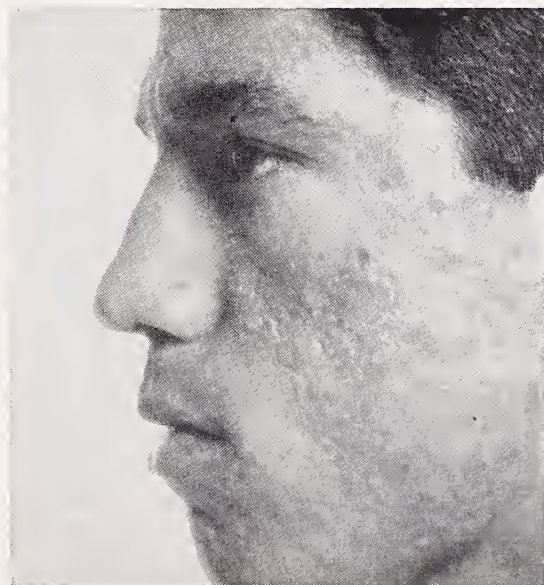
3. elderly or debilitated patients



4. patients with a past history of moniliasis



5. patients on long-term tetracycline or cortico-  
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traindicated in patients hypersensitive to its component  
tetracyclines. **Warnings:** Photodynamic reactions have been produced  
by tetracyclines. Natural and artificial sunlight should  
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fort occurs. With renal impairment, systemic accumulation of  
the drug may occur. In this situation, lower doses should  
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induced during tooth development (last trimester of  
pregnancy, neonatal period and childhood). **Precautions:**  
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be conducted initially and monthly for 3 months. **Adverse  
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may occur. **Usual Adult Dosage:** 1 capsule *q.i.d.* Continue  
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# THE ROLE OF THE PHYSIATRIST IN POST-THORACIC SURGERY

Albert Haas, M.D.; Pierre Gayrard, M.D., and Herbert Dietz, M.D., *New York, N.Y.*

- Exercises should start pre-operatively and be continued for at least six months.

WITH THE DEVELOPMENT of improved methods of anesthesia and the availability of effective antimicrobial drugs, thoracic surgery has made remarkable advances in the last two decades. However, the most skillfully performed thoracic surgery is bound to leave serious pathologic residua, anatomic and physiologic.<sup>1</sup> In opening the chest wall, the surgeon, however skillful, is forced to cut through the large muscles of the operative area, muscles that are vitally important in shoulder girdle mobility and trunk posture.

As a rule, during the operation the fibers of the trapezius, rhomboid major, latissimus dorsi and serratus anterior muscles are sectioned and, although ultimately repaired, still inevitably show varying degrees of posttraumatic atrophy and dysfunction which may result in chronic malfunction and possible deformity of the thorax.

## Muscles Resutured

In thoracic surgery, as in all other surgery, the severed muscles are usually resutured, resulting in their being shortened and weakened. Studies in physiology of muscle activity have demonstrated that muscle function is best when contraction is initiated with the muscle in its normal resting length. Traumatic shortening, therefore, is conducive to inefficient functioning. Thus with the muscles of the involved side anatomically and physiologically impaired, the contralateral muscles become much stronger, pulling and twisting the spinal column and the rib cage into possible deformity.

The operative trauma leaves a trail of fibrosis, matted soft tissues and atrophy plus considerable discomfort or pain, thus encouraging dysfunction, mal-

position and ankylosis of varying degree. The functional complexity of the back muscles<sup>2</sup> is such that trauma inflicted to any one of the muscles seriously upsets the synergistic action of the whole group, and consequently results in an imbalance of the upper trunk and in varying limitations of range of motion of the arm on the affected side. To anticipate and counteract, as far as possible, the permanent post-operative sequelae, the physiatrist must consider the whole functional complexity and interrelationship of all back muscles on both sides and apply the therapeutic measures accordingly. In some instances, however, additional unexpected complications arise post-operatively. In closed thoracotomies, a tube is inserted into the pleural cavity through the middle fibers of the serratus anterior muscle on the edge of the latissimus dorsi muscle (Figure 1). The irritation caused by the tube and the resultant pain produced by movement of the arms frequently force the patient to lock his arm to the side in an effort to immobilize the shoulder girdle for prolonged periods of time, leading to varying degrees of fibrotic ankylosis. Due to the same factors (the irritation of the tube and the pain), the latissimus dorsi muscle, instead of relaxing when the arm is fully flexed, remains in a contracted stage, interfering with the synergistic action of the serratus, the trapezius and the pectorallis muscles, resulting in various degrees of limitation in shoulder girdle function.

It is essential that, when applying appropriate exercises, it be emphasized that the inserted tube remain in situ. Appropriate exercises are described in Rusk's *Rehabilitation Medicine*.<sup>3</sup> A bed pulley can also be installed and the patient should be encouraged to use this helpful device. The pain cannot be entirely avoided but can be substantially reduced with heat, infrared, diathermy, etc.

Another complication arising from thoracic surgery is damage to the nerve supply as a result of unintentional trauma to the subclavicular part of

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*Presented at the 112th Annual Session of the Medical Association of Georgia, May 8, 1966, Columbus, Georgia.*

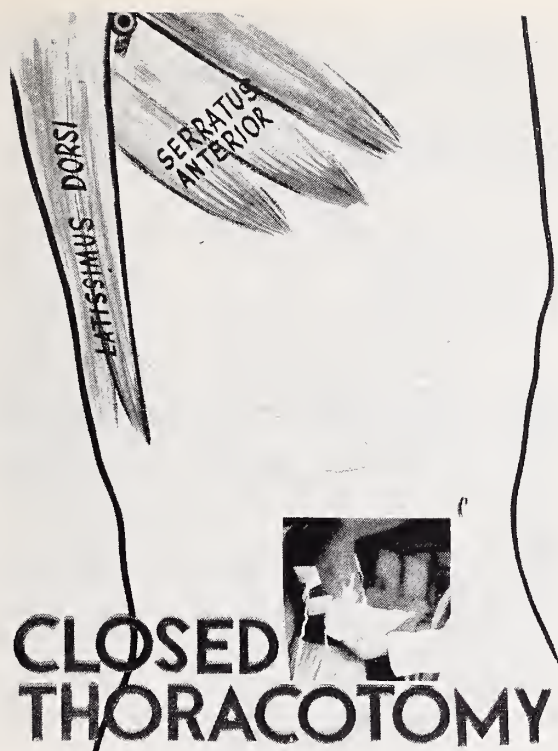


FIGURE 1  
The position of the tube in closed thoracotomy

the brachial plexus. The trauma may be caused by undetected pressure while the patient is on the operating table or may be due to accidental stretching of a branch of the brachial plexus during resectional surgery. Since, as a rule, the patient lies on the unaffected side in a lateral position during surgery, the pressure neuritis may occur on the unaffected side, resulting in a palsy of one of the branches of the brachial plexus—axillary, radial, median or ulnar nerves (Figure 2). Routine physical therapy measures (heat, interrupted galvanic currents, exercise, etc.) speed recovery to normal unless the trauma and the incidental damage to the nerve have been severe and irreversible. In such cases, recovery will be quite slow or impossible.

Similarly, injury of a nerve due to accidental stretching during the operation varies in intensity with the severity of the trauma. A most common complication is radial palsy with wrist drop that may be mild, moderate or severe. It is desirable to detect such nerve injury early in order to institute effective therapy to prevent secondary degeneration and crippling changes in the affected limb. With new electronic devices, diagnosis of the nerve involvement is relatively easy. Electro-diagnostic measures such as galvanofaradic, electromyography, etc. help in evaluating the extent of the trauma and the rate of recovery of nerve function.

A corrective therapy program should be divided into two distinct phases: pre-operative and post-operative. The objective of the former is to educate and strengthen the synergist muscles not directly affected by the operative procedure so that they may

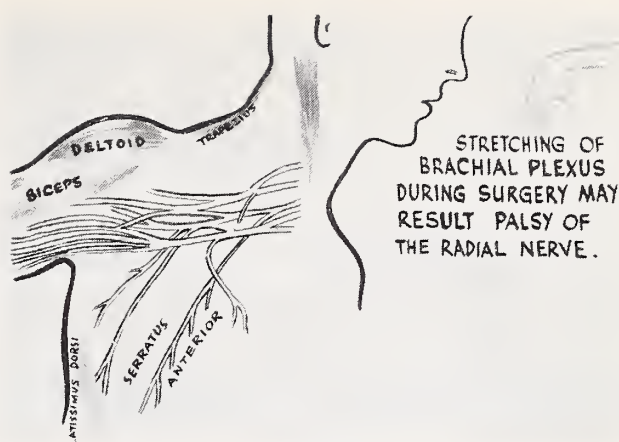


FIGURE 2  
Diagram of the brachial plexus

take over, in so far as possible, the functions of the primary muscles which are temporarily disabled.

### Immediately After Surgery

The second phase—post-operative corrective exercises—should start immediately after completion of the surgery. The corrective exercises are divided into: (1) passive, where the entire movement is carried out by the therapist, (2) assistive (active-assistive), where the patient does as much as he is capable of and the therapist completes the indicated range of motion, (3) active, where all the motion is carried out by the patient himself and (4) active-resistive, where “load” is added to the exercise in order to increase the power of the muscles (isotonic and isometric exercises).

The necessity of using oxygen therapy is no contraindication to an early and persevering reconditioning program.<sup>4</sup>

The therapeutic exercises are of recognized value in reestablishing muscle function and range of motion in post-surgical cases. However, to achieve better reexpansion after excisional surgery and enhance pulmonary ventilation, breathing exercises are a recognized addendum to the post-operative management of these patients. Their purpose is two-fold:

(1) To gain full expansion of the affected side of the chest in order to restore best possible ventilation and to prevent eventual chest deformities.

(2) By localization to be able to expand areas of the lung where secretions may accumulate post-operatively and thus to induce effective cough to expectorate the secretions.<sup>3</sup>

### Conclusion

The role of the physiatrist is to minimize the post-operative sequelae by applying the therapeutic modalities. The exercises should start pre-operatively and continue post-operatively throughout the hospital stay and the patient should be instructed to continue them at home for at least six months, with periodic



## POST-THORACIC SURGERY / Haas et al

follow-up and re-examination. If diligently applied, these exercises will minimize the incidence of impaired range of motion and eventual deformity.

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## 1967 CALENDAR OF MEETINGS

### State

- January 12-14—Symposium on "Forensic Medicine: The Doctor and the Law," Mound Park Hospital Foundation, Inc., St. Petersburg, Fla.
- January 20-21—"Seminar on Burns," sponsored by the University of Florida College of Medicine, Gainesville, Fla.
- January 27, 1967—Vincristine Symposium, "Current concepts of biological, pharmacological and biochemical action, and comprehensive summaries of therapeutic results obtained in treating solid tumors and the leukemias," sponsored by the Pediatric Division of the Southwest Cancer Chemotherapy Study Group, St. Jude Children's Hospital, Memphis, Tenn.
- March 1-3—"Acquired Valvular and Congenital Heart Diseases," sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.
- March 2-4—Seminar on "Some Aspects of Embryology and Pathophysiology of Congenital Heart Disease," sponsored by the University of Florida College of Medicine, Gainesville, Fla.
- March 14-15—"Pediatric, Adolescent and Geriatric Gynecology," sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.
- March 16-17—Seminar in Obstetrics and Gynecology sponsored by the University of Florida College of Medicine, Gainesville, Fla.
- March 17—Regional Meeting of Psychosomatic Medicine and Seminar on "Psychomatic Aspects of Gastrointestinal Disease," sponsored by the University of Florida College of Medicine, Gainesville, Fla.
- March 21-22—"Rheumatic Diseases," sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.
- March 24-25—Seminar on Tropical Disease sponsored by the University of Florida College of Medicine, Gainesville, Fla.
- April 3-7—Fortieth Annual Spring Congress in Ophthalmology and Otolaryngology sponsored by the Gill Memorial Eye, Ear, and Throat Hospital, Roanoke, Va.
- April 6-7—"Auscultation of the Heart, Phonocardiography and Pulse Tracings," offered by the Institute for Cardiovascular Diseases, Good Samaritan Hospital, Phoenix, Arizona. Program to be held at the Mountain Shadows Resort, Scottsdale.
- April 13-14—Obstetrics and Gynecology Seminar sponsored by the University of Florida College of Medicine, Gainesville, Fla.
- April 20-21—"The Adrenals in Health and Disease," sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.
- April 30-May 1-2—113th Annual Session of the Medical Association of Georgia, Marriott Motor Hotel, Atlanta.

### National

- January 8-10—First Annual Clinical Meeting of the Society for Cryo-Ophthalmology, Dunes Hotel, Las Vegas, Nev.
- June 18-22—American Medical Association Annual Convention, Atlantic City, N.J.

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# THE MANY FACES OF DEXTRAN

Milton F. Bryant, M.D.; Walter L. Bloom, M.D.  
and Spencer S. Brewer, M.D., *Atlanta*

- The potential uses for this long-chain polysaccharide have become manifold.

THE NEED for large quantities of a readily available plasma volume expander became apparent during World War II and was crystallized by the introduction of atomic warfare at Hiroshima in August, 1945. The work of Gronwall and Ingelman<sup>1</sup> in Sweden and Bloom<sup>2, 3, 4</sup> in this country led to the development of a long-chain glucosidic polysaccharide—"dextran"—a very effective plasma volume expander. Quantities of clinical dextran have been stockpiled by the Department of Defense in the event of a national emergency. Recently published studies show that the dextran molecule, after years of observation, is stable and suitable for long-term storage.<sup>5</sup>

## Early Studies

Early studies revealed that dextran was as effective as serum albumin in expanding the plasma volume. In addition, it was found to be relatively non-toxic if infusions were limited to 7 to 21 cc per Kg. of a 6% solution. Bloom and others noted that infusions of larger quantities of dextran produced a bleeding tendency. Initially, the cause of the bleeding tendency was thought to be related to the secondary distention of the vascular bed along with dilution of coagulation factors. Subsequently, Bryant, Bloom and Brewer<sup>6, 7</sup> defined further the nature of the induced hemostatic defect and proposed the use of clinical dextran as an anti-thrombotic agent.<sup>8, 9</sup>

In 1960, a study was begun in the Ferst Research Laboratory of Piedmont Hospital to explore better ways to prevent post-operative thrombosis of small arteries. An experimental preparation was developed and subsequent studies revealed that heparin, prothrombin depressant drugs, and the available fibrinolytic preparations were ineffective in preventing post-operative thrombosis in small arteries subjected to a standardized surgical trauma. The earlier observations of Bloom and Fowler led to the experimental evaluation of the use of clinical dextran in preventing

thrombosis in traumatized small arteries. The gratifying results of this study were reported in the *Journal of the Medical Association of Georgia* in December, 1961.<sup>6</sup> Dr. Robert Buxton, Professor of Surgery at the University of Maryland, and Col. John Moncrief, Director of the Surgical Research Unit, Fort Sam Houston, Texas, were informed of these findings and they have repeated, confirmed and added to these observations.

## Low Molecular Weight Dextran

Several reports have indicated that low molecular weight dextran (average molecular weight 43,000) is effective in preventing thrombosis in a wide variety of clinical situations.<sup>9, 10, 11, 12</sup> Careful evaluation of the anti-thrombotic properties of dextrans of low average molecular weight revealed the anti-thrombotic effect of these dextran preparations to be more transient and, in clinical situations, not as effective as clinical dextran.<sup>9</sup> This is due, in part, to the rapid rate with which dextrans of low molecular weight are filtered through the kidney as well as the physical chemical properties of the smaller molecules.

A single infusion of clinical dextran is gradually cleared from the vascular compartment in six to eight days. It was hypothesized that dextrans of high molecular weight might be held in the intravascular compartment and have a more prolonged anti-thrombotic effect. Laboratory study showed that the high molecular weight dextrans were inferior to "clinical dextran" in preventing intravascular thrombosis.<sup>13</sup>

## Thrombosis in the Venous System

Since clinical dextran was found to be effective in preventing post-traumatic thrombosis in the arterial system, it seems logical to assume that it would prevent thrombosis in the venous system. Laboratory and clinical studies have shown that clinical dextran will prevent experimental thrombosis in veins and is effective in treating patients with acute thrombophlebitis. To date, many patients with throm-

*From the Ferst Research Laboratory, Piedmont Hospital.*



bophlebitis have been successfully treated with dextran.<sup>14</sup>

In 1962, several patients with recurrent thrombophlebitis were placed on weekly infusions of clinical dextran with control of the recurrent episodes. Some patients were treated for many months with weekly infusions. It appears that if one can maintain these patients in an improved state for a long period of time with dextran therapy, the tendency for recurrent attacks of thrombophlebitis abates after the regular infusions are discontinued.

The effect of dextran on the blood cholesterol level was evaluated in 1962. In patients with idiopathic recurrent thrombophlebitis, the cholesterol level was found to fall after dextran therapy. Patients with hypercholesterolemia were studied and dextran therapy was observed to markedly lower the level of the serum cholesterol. We concluded that weekly infusions of dextran would lower the blood cholesterol—the higher the initial cholesterol level, the greater the fall. The cholesterol level can be reduced as long as the patient receives the weekly infusions of dextran. After the infusions are discontinued, the cholesterol level will return to its original state. This finding was reported at the annual meeting of the Frederick A. Collier Surgical Society in Reno, Nevada, 1962.

At the time these studies were being performed at Piedmont Hospital, Dr. William Schatten was studying various aspects of transplantable tumors in rabbits. Studies showed that dextran was a surface coating agent and it was speculated that dextran might coat the surface of neoplastic cells and prevent metastatic implantation. This hypothesis was studied by Dr. Schatten and found to be true.<sup>15</sup>

### Summary

1. Clinical dextran is a valuable plasma volume expander. When used as a volume expander, the total dose should not exceed 7 to 21 cc/Kg.

2. Dextran possesses anti-thrombotic properties which make it a useful agent in preventing and treating thrombo-embolic disease. Dextran has been used effectively to treat patients with thrombophlebitis and pulmonary embolism. Therapy should preferably be started within 48 hours—and given in a dosage equal to 1% of the body weight of a 6% dextran solution (i.e. 70 Kg.  $\times$  1% = 700 cc). It is suggested that if the cardiac reserve is adequate that this dosage be repeated every 24 to 36 hours for three more infusions. Subsequent infusions can be given at five to seven day intervals.

3. It is recommended that a 1% of body weight infusion be given at the beginning of all reconstruc-

tive vascular procedures. If indicated, this dosage should be repeated on the fifth post-operative day.

4. All patients with arterial emboli should be given dextran.

5. It is probable that all patients undergoing major surgery, or any illness in which thromboembolism is likely to occur, should receive a prophylactic infusion of clinical dextran. The infusion can be repeated every five days.

6. The possibility that dextran may retard metastatic implants during surgery should be kept in mind.

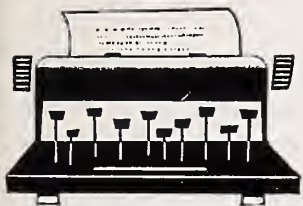
7. The serum cholesterol level of some patients with hypercholesterolemia can be lowered with weekly infusions of dextran. Whether or not this is beneficial is unknown at this time.

8. The use of dextran in acute myocardial infarction is being studied. At the present time, it should only be used by physicians carrying out a carefully controlled research project.

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# EDITORIALS

## Measles 1967

**A**N URGENT OPPORTUNITY is beckoning the medical profession in Georgia.

One of the destructive and costly scourges of mankind can be eliminated in 1966-67. The administration of live measles vaccine to approximately 80% of Georgia's susceptible children can bring about a situation comparable to what has been achieved with the elimination of smallpox and poliomyelitis. However, this will require a joint plan and effort by the state and local medical societies and health departments, as well as individual physicians.

### Mass Campaigns Necessary

Mass campaigns may be necessary. Throughout the United States many intensive measles immunization programs have been conducted or are in the planning stage. One needs to aim at only 15% of the total population as compared with the Sabin Vaccine programs. It will be difficult to get to some of the children that need it most—those in the lower socio-economic group and all susceptibles in the school age population. It is essential that we break the chain of transmission by immunizing all children without a history of measles up to age 12. The administration of vaccine to all children at approximately one year of age must continue whether this be performed in the private office or health clinic. Protecting one group will not solve the problem for all.

Some of the interesting facts about measles in the United States are: 1) approximately four million children acquire measles every year, 2) one in six develop serious complications including respiratory illness, 3) hundreds die from encephalitis and pneumonia, 4) some four thousand develop encephalitis of which one-third become brain damaged or mentally retarded, 5) more than half have transient ab-

normal electroencephalographs, 6) four out of ten contract the disease before the age of five and nine out of ten contract it before the age of 12, and 7) epidemics occur every two to three years.

### Live Vaccine Effective

The live vaccines have proven to be effective, safe, and provide long lasting immunity. Contraindications to vaccination are few. Again, the focus is on the child population to eliminate the source of infection.

The expense is considerable but is negligible in light of the cost of human suffering, institutionalization of the neurologically damaged, medicines, physicians' and hospital services, parents' workdays and income lost, and school absences.

Dr. William H. Stewart, Surgeon General, U. S. Public Health Service, has outlined a four point program for eradicating measles before the end of 1967:

"1. Routine immunization of all children when they are one year old. Nearly all health departments have measles vaccine for those who cannot afford it.

"2. Immunization of any susceptible children found in kindergarten, first, and second grades.

"3. The development of improved reporting systems for finding out when and where measles cases occur, so more effective control measures can be designed.

"4. The stopping of epidemics where not enough children have been vaccinated by launching crash immunization programs. Epidemics of measles can no longer be tolerated in the United States."

As physicians and responsible citizens we must plan and establish an effective program in Georgia NOW.

*Joseph H. Patterson, M.D.  
1405 Clifton Road, N.E.  
Atlanta, Georgia*



## A Christmas Story "Surprise"

SOME YEARS AGO I was duck hunting on one of the lakes in south Florida. Our host was the father of a good friend. He was a pioneer in those parts and kept us enthralled with stories of long ago.

It was about a week before Christmas and this night concluded three days of a most gratifying duck shoot. We sat around in the living room after a bountiful meal. Although we didn't need a fire, he had a small fireplace and kept one going by throwing on little pieces of scrub pine. I remarked that my wife was going to be in for a big surprise this Christmas because I, for a change, was going to bring in some ducks. So many times, I said "I come in 'sans' ducks—many excuses."

"Speaking of surprises, and wives," my host said, "I remember many years ago. . . ."

### A Sweet Potato Farmer

There was an old man who lived out about ten miles from town. He had a small farm of very fertile land; he raised a family of four or five children and did well. But as they grew up, the children left the farm one by one and went North. As time went on, the old couple were left all alone and got down to one mule by the name of Maud and all the accessories that would go with one mule. Their garden furnished them vegetables through the year; the lake had fish and the woods had game. Their money crop was sweet potatoes which grew bountifully in this sandy soil. Sweet potatoes did not have to be sold quickly, as tomatoes, beans and other vegetables did—they could be kept a while and carried to market leisurely. All old farmers dislike intensely any crop that has to be harvested on a certain day and sold immediately. There might be a political speech or "big meeting" going on at the time. They want a crop they can gather and then sell when nothing exciting is in the air. Such was true of sweet potatoes.

Anyway, about a week before Christmas the old man loaded about 20 bushels of potatoes on his one-horse wagon and drove to the village to sell them. Much to his amazement, he learned that the price, instead of 50 cents a bushel which he had usually gotten, was now up to two dollars a bushel—other areas had had a drought.

He counted his money several times; went back to his wagon and stood in front of old Maud as he counted it the last time. He said, "Maud, let's sur-

prise the old woman—I think I'll go buy her a complete new outfit; it's Christmas and we'll surprise her." And he did; hat, dress, shoes, stockings, underwear—but not to exceed, so he told Miss Julia at the store—fifteen dollars.

All the way back to the farm that afternoon, he nestled the two packages under the plank across the front of the wagon. It was only as he neared home in the darkness that he commenced wondering how he was going to hide the packages until Christmas. Maybe he could slip into the barn and he pulled Maud down to a slow walk; she always got into a hurry as she neared the barn. But just as he feared, when he was within hollering distance from the house, the old woman lighted a lantern and opened the lot gate. As he drove Maud through, his wife wanted to know how much he got for the potatoes and what was the news from town. He hummed and hawed and told her he was hungry, and that he would feed Maud and for her to go on in the house. But she said supper was on the table and that she would help him as she had always done.

Naturally she spied the two packages, one large and one small—and again he hummed and hawed. He finally told her it was to be a surprise for her. He confessed the price he had gotten for the potatoes—confessed also he was going to surprise her on Christmas morning.

### Pleased With Himself

He was pleased with himself, she could tell, as he ate heartily of the simple meal. The old woman toyed with hers, she took a bite, looked at the devilish gleam in her husband's eyes, then looked at the packages and repeated the procedure several times. Finally in desperation, she stood erect and said something she had heard her mother say before her—"there's something rotten in Denmark," and proceeded forthwith to open the packages.

When she saw the dress with the lace on top, and held it up in front of her, she looked into the wrinkled and weather-beaten face of her grinning husband and dissolved into tears. With each other item—shoes, hat, stockings and petticoats she wept, and great was her joy thereof. She vowed that she was the happiest woman in the whole state of Florida—and that this was a great surprise and would be the happiest Christmas ever.

The next morning she fixed a good breakfast, but was quiet all through the meal. When it was finished she went around the table; put her arm around the shoulder of her husband and said, "You've given me one big happy surprise this Christmas and now I want you to give me another one—take the rest of the potatoes on in that you were going to sell after Christmas and buy yourself a new outfit."

### Because She Was Happy

He argued that this would not be a surprise and that he already had two pair of overalls, that he was happy because she was happy, and that they could use the money elsewhere. All to no avail as she, like most women, could badger a man into anything, given time. Finally on Christmas Eve morning, a beautiful warm day, he and Maud set out—sold their potatoes, and he bought himself a new pair of overalls, shirt, hat, underwear, shoes and socks. He went back to his wagon and told Maud that this wouldn't be no surprise like the last one. Then he happened to think about needing a haircut. He put his clothes under the plank across the wagon that he sat on and proceeded on to the barber shop. He emerged with his head feeling chilly and smelling strongly of lilac talcum powder.

On the way home, as he was fingering his store bought clothes, he had another idea—that was to go

by the creek, take a bath and really dress up in his new clothes. That would surprise her. On the edge of the creek bank, just before sundown, he emptied his pockets—money pouch, chewing tobacco, pocket knife, matches and a long thin strip of raw hide. He carefully put them all under a nearby bush of palmetto. Then he looked at his old faded and patched overalls and shirt; his worn out shoes and grimy socks. For some reason a foolish urge came on him, and as to took them off, he threw them as far out in the creek as he could and took a fiendish delight in seeing them slowly go downstream and sink.

He washed good, all except his head. He shook himself and listened to the frogs a while as he dried off. Then he cautiously tiptoed back up the path to the wagon in the twilight. When he reached under the wagon plank to get his clothes—they were gone. . . . The old man put his hand and forehead on Maud's warm hip and stood dumb for a minute or two—then a slow smile came on his face, a twinkle in his eye. He climbed slowly back on the wagon, slapped Maud on the hindside, and said:

"Giddup Maud, this Christmas we'll really surprise the old woman twice't."

*J. G. McDaniel, M.D.  
508 Grand Theater Building  
Atlanta, Georgia 30303*

## Field Service—An Innovation

IT IS GENERALLY conceded that ours is a complex society fraught with a variety of activities of our own choosing, big government intervention notwithstanding. Nevertheless, we must never lose sight of the fact that it is extremely important that organized medicine, at all levels, concentrate on ways and means of maintaining the basic constitutional objective—that of promoting the science and art of medicine and the betterment of public health.

The lack of effective communications between all levels has heretofore left Georgia medicine in a somewhat precarious position, in that county medical society contacts with MAG were a once-a-year occurrence during the course of the Annual Session. During the interim, contact with component societies was limited to the promotion of legislative programs or other specific projects of timely interest.

### A Better Way

Realizing that there must be a better and more effective way of communicating the affairs of MAG,

and at the same time creating a better working relationship with county medical societies, the House of Delegates assembled in Columbus last April gave overwhelming support and approval to a recommendation by Dr. John T. Mauldin, then Secretary of the Association. In his report, Dr. Mauldin called attention to the fact that, "the future of the practice of medicine will depend on the united action through the Medical Association of Georgia." He further noted that, "in order to obtain better dissemination of information in both directions to and from county societies, and to encourage more activities of District Societies, because of their political importance, it is recommended that the Council of the Medical Association of Georgia be instructed to study and prepare a long range plan for a field service and to implement these plans in a reasonable period of time."

This action set the stage for what many believe to be one of the most important single efforts that the House of Delegates has favorably considered in



recent times—that of employment of a field service representative. In due process, a representative was engaged and after a period of about six weeks of observing all facets of activity in the Headquarters Office, he began meeting with county medical society officials.

### A Genuine Welcome

The initial welcome awaiting MAG's man in the field and the eagerness of county medical society officials to discuss mutual affairs was genuine and suggests the endorsement by the societies of the House of Delegates' decision to add field service as part of the MAG program. This auspicious beginning can but enhance the relationship of all groups in order to establish better lines of communication and in helping to weld together a bigger and better organization.

With field service devoting about 75% of its time working with local societies, it seems that the previous void is destined to become less apparent in the ensuing weeks and months. Seventy-nine county medical societies comprise MAG. It is evident that it will require several weeks to visit every area of the state. First thoughts indicate "making the rounds" twice yearly on a scheduled basis. If this plan is carried to fruition, a stronger and more enthusiastic organization is inevitable.

### Bridging the Gap

It should be emphasized that the addition of a field service representative is a means of bridging the gap which has existed for too long a time between MAG and component medical societies. Each local society is obliged to utilize the services of this division of the MAG Headquarters Office which may very well be the catalyst needed to help transform an inactive society into a more dynamic one.

## PMA CHAIRMAN DUNCAN SEES RISE IN BOOTLEG DRUGS, WARNS OF RETURN OF PROHIBITION-STYLE RACKETEERS

Prohibition-style racketeers, scenting millions of dollars in bootleg drugs, are beginning to invade the prescription drug market under cover of pressure for lower prices, Lyman C. Duncan, chairman of the Pharmaceutical Manufacturers Association, said recently.

A rising tide of "bootleg drugs" could impose a task on Food and Drug Administration agents as difficult as that of revenue agents searching for bootleg stills in Prohibition days, Mr. Duncan warned at the annual meeting of the National Association of Retail Drug-gists.

### Protection Could Be Demolished

He said the protection once afforded doctors and their patients by the manufacturer's name on his products was "in danger of being demolished" by governmental action to promote the use of unbranded, and presumably cheaper, drugs.

In the past, Mr. Duncan said, the chief requirement of an FDA inspector was technical knowledge of pharmaceutical products and manufacturing processes. The reliance on manufacturers' integrity "made it possible to police this vast industry successfully with a mere handful of technically-oriented FDA inspectors."

Now, with FDA's assignment of policing the potency, purity and safety of drugs, and the advent of "bootleggers," Mr. Duncan went on, the agency will require "pistol-packing investigators skilled in underworld procedures." He said they will have to search for the illicit and shady operators turning out complex and dangerous drugs in the industrial fringes of New Jer-

sey and the outskirts of major cities such as Chicago and Detroit.

Mr. Duncan told the assemblage of retail pharmacists, "The illicit industry is still relatively small but the important thing is the seeds have been sown and the method of operation established. Their mushrooming growth only awaits the opening up of the vast new market which the campaign for generic prescribing will provide."

### The Victim

He said that many of the best known and most effective drugs in use today—steroids, antibiotics, diuretics and others—were the object of smugglers, counterfeiters and "all the illicit makers and purveyors of drugs of unknown and unspecified origin."

He recalled that the Lederle Laboratories division of his own company, American Cyanamid, of which he is vice president for medical affairs, was the victim of thieves who sold stolen cultures and materials to Italian drug companies. These companies in turn sold drugs made from the stolen materials back to the United States Government. He said such thefts, drugs smuggled from behind the Iron Curtain, illicit manufacture and counterfeiting in the United States, were of less significance in the past because the market for illicit drugs was small.

Now, with the brand-name lid off and the market potential of perhaps \$100 million, "the gentlemen who run the rackets and nefarious business enterprises in the United States are already well aware of the new opportunities that have been opened up for them in the field of pharmaceutical products," he said.

# MILITARY MEDICAL BENEFITS EXPANDED FOR DEPENDENTS' MEDICAL CARE PROGRAM

**T**O: All Georgia Licensed Doctors of Medicine

## RE: EXPANSION OF "DEPENDENTS' MEDICAL CARE PROGRAM" AS PROVIDED IN PUBLIC LAW 89-614, MILITARY MEDICAL BENEFITS AMENDMENTS OF 1966.

This letter gives information on the new expanded benefits authorized by Congress and signed into law on September 30, 1966. The Medical Association of Georgia will continue to act in the capacity of Fiscal Administrator for physicians' portion of inpatient care, plus *ALL* claims for outpatient care.

The new health benefits fall roughly into three broad categories phased with different effective dates:

1. *Civilian outpatient care* for dependent spouses and children of members of the uniformed services who are serving on *active duty* for more than 30 days. This portion became effective October 1, 1966. See list at end of article for Authorized and Unauthorized care.

2. *Civilian inpatient and outpatient care for retired members* and their dependent spouses and children, and the dependent spouses and children of members who died while on active duty or in a retired status, effective January 1, 1967.

3. Training, rehabilitation, special education and institutional care in civilian facilities for the dependent spouses and children of active duty members who are moderately or profoundly mentally retarded or who have a serious physical handicap, effective January 1, 1967, also.

### Outpatient Care Deductible and Co-Insurance:

1. Dependents of active duty personnel.

a. Outpatient care. The patient shall be required to pay the first \$50.00 per person, or, \$100.00 per family, of charges for authorized outpatient care during fiscal year and 20% of all charges thereafter. In satisfying the deductible, all authorized outpatient charges may be included. Nonavailability Statements from Military Facilities *will not* be required.

b. Inpatient care. Care related to pregnancy and services provided 30 days before and within 120 days after hospitalization for injury or surgery are considered as inpatient care for the purpose of com-

puting the patient's share of the charges. The Non-availability Statements from Military Facilities *will be* required when patient and sponsor reside together, as in the past.

2. Retired personnel, their dependents and dependents of Deceased personnel.

a. Outpatient care. Same initial deductible as active duty personnel, *plus* 25% of additional charges for authorized care.

b. Inpatient care. This category of beneficiaries will be required to pay 25% of *all* charges for inpatient care.

### Record of Outpatient Care Deductible:

Patients must collect and retain *paid receipts* up to the amount of the annual deductible. These receipts must bear: (1) name of patient; (2) date and type of services; and (3) signature of physician rendering care. When the patient has collected receipts to meet the annual deductible, these receipts should be mailed by the patient to the Fiscal Administrator, along with a DA 1863-2 Form completed through item #13 for identification as an eligible recipient. The Fiscal Administrator will then provide the patient with a "Certificate" indicating the annual deductible has been met. Unless the patient has such a certificate in his possession, the physician or other source of care should bill the patient direct.

### Outpatient Care Charges and Reimbursement:

After the deductible has been met, the physician may bill the Fiscal Administrator direct for authorized outpatient care. The Government will then pay 80%; the patient 20% (or 25%-retired) in accordance with the provisions of the Program. If the patient elects to make payment in full, they may file for reimbursement of the amount authorized for payment. Forms for filing are available upon request from the Medical Association of Georgia.

For outpatient routine home or office visits, the usual, customary, and reasonable charges submitted may be paid, subject to contract provisions. All other outpatient care, i.e., surgical procedures, radiology, pathology, etc., will be subject to the appropriate Schedule of Allowances used in the present inpatient care program.



## MILITARY CARE / Continued

The outpatient care program will operate under the same "Full-Payment" concept on reimbursement as presently applies to the inpatient care program with the existing system of medical review committees to advise the Fiscal Administrator in the determination of reasonable charges. In short, once payment has been effected as described, neither the Government nor the patient has further financial liability.

### Physician Licensure in Georgia:

The Fiscal Administrator by regulation can only reimburse Georgia licensed physicians *whose renewal of their license is current.*

### Prescription Drugs:

The Fiscal Administrator will reimburse Georgia licensed pharmacists filling prescriptions (legend drugs) for eligible recipients under this new expanded program, subject to deductibles and co-insurance described above. Detailed information will be mailed to pharmacists in the near future.

### Outpatient Care Authorized as of October 1, 1966:

- a. Treatment of:
  - (1) medical and surgical conditions
  - (2) nervous and mental disorders
  - (3) chronic conditions and diseases
  - (4) contagious diseases
  - (5) bodily injury (\$15.00 deductible no longer applicable. Subject to deductible outlined on page 1)
- b. Diagnostic examinations, including X-Ray, Laboratory, basal metabolism, electrocardiogram,

electroencephalogram and radioisotope examinations

- c. Anesthetics and their administration
- d. Oxygen and equipment for its administration
- e. Physical therapy
- f. Orthopedic braces (except orthopedic shoes) and crutches
- g. Dental care *required as a necessary adjunct to medical or surgical treatment*
- h. Local ambulance service to or from a hospital for purpose of receiving inpatient care or outpatient accident care
- i. Drugs and medicines limited to: (1) Drugs and medicines obtainable only by written prescription (legend drugs) and (2) Insulin. Incidentally, copies of prescriptions will be required for reimbursement
- j. Artificial limbs and artificial eyes, including initial issue and fitting, replacement, repair and adjustment
- k. Durable equipment, such as wheelchairs, iron lungs, and hospital beds, on a *rental basis*
- l. Routine physical examinations and immunizations **ONLY** when required by spouses and children who are under orders to travel outside the United States as a result of a members duty assignment
- m. Family planning services.

### Outpatient Care Not Authorized:

- a. Routine care of newborn and well-baby care
- b. Eyeglasses or examinations for eyeglasses
- c. Prosthetic devices (other than artificial limbs and artificial eyes), hearing aids, and orthopedic shoes
- d. Routine physicals and dental care except as noted above

## THIRTIETH ANNUAL MEETING OF THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY TO BE HELD MARCH 6-9, 1967

The thirtieth annual meeting of The New Orleans Graduate Medical Assembly will be held March 6, 7, 8, 9, 1967, with headquarters at The Roosevelt Hotel.

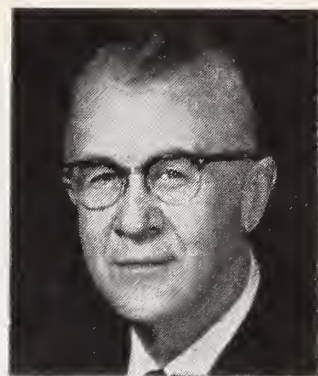
Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 51 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, round-

table luncheons and technical exhibits. This program is acceptable for thirty and one-half (30½) accredited hours by the American Academy of General Practice.

An interesting and enjoyable program of entertainment for visiting ladies has been planned.

For information concerning the Assembly meeting write *Secretary, The New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, Room 1528, New Orleans, Louisiana 70112.*

## PRESIDENT'S LETTER



# THE END OF ANOTHER YEAR

AS THIS IS WRITTEN we are approaching the end of another year. A year in which we have seen great changes take place in all facets and activities of our life. In our profession these are permanent and radical ones which direct and control how we shall look to the future for further directives and regulations.

Gradually, but surely, our previous manner of handling our relations with our patients will continue to be regulated by law and by edict. The avowed purpose of our government is to continue to expand its activities in the field of medical care and treatment as rapidly as possible to include all categories of those requiring our attention and to control how this shall be done.

### Recent Expansion

Recent expansion of these programs now includes outpatient care for military dependents, including dental care when advised by a medical doctor. Also to come will be outpatient care for retired military personnel. Dental care for children under six is now provided.

Title XIX is to be rapidly activated to include care of medically indigent, dependent children, blind, totally disabled and many other categories. The "Medicaid" provision for medicare for families of six with income of \$6,000 or less is now law in seven states and will be activated in others.

### Four Months of Medicare

Four months of medicare has now passed, 350,000 physicians bills have been paid, 650,000 have received home health services, 6,750 hospitals have been utilized, 250,000 physicians have participated. There are still approximately 600 hospitals now only conditionally certified for participation and 280 rejected. Many of these rejected facilities are in the South where steps to admit and treat patients on a

non-discriminatory basis have not been taken, according to Health, Education, and Welfare.

All this above has required a great amount of extra work, record keeping, processing forms, book-keeping changes, etc., in hospitals and our offices.

In our state we have enacted the planning portion of the Heart, Cancer and Stroke program and the proposed budget for this has been submitted to Washington for study, adjustment and approval.

Our mental health and care for retarded children program is extremely active. New recommendations of the Bowdoin Commission are being pushed as rapidly as possible.

### Improved and Expanded Programs

The new center for care of mentally retarded in Atlanta is under way. New facilities in Augusta, Savannah, Athens and at Battey Hospital, Rome, are now in the process of being activated. Improvements at Gracewood and Milledgeville continue. The Thomasville facility is open and now has approximately 200 patients.

Both candidates for governor have assured us that they will work actively for greatly increased appropriations to continue these improved and expanded programs.

We wish for all a happy and joyous Christmas season. For all also this will be a season for prayer and reflection for the grave situation in which our country finds itself. Many of us have loved ones and friends in Viet Nam and observance of this occasion will be tempered by these facts. May we soon see an end to this tragic and grievous war.

A cursive handwritten signature that reads "Walter Brown".

Walter E. Brown, M.D.

*President, Medical Association of Georgia*

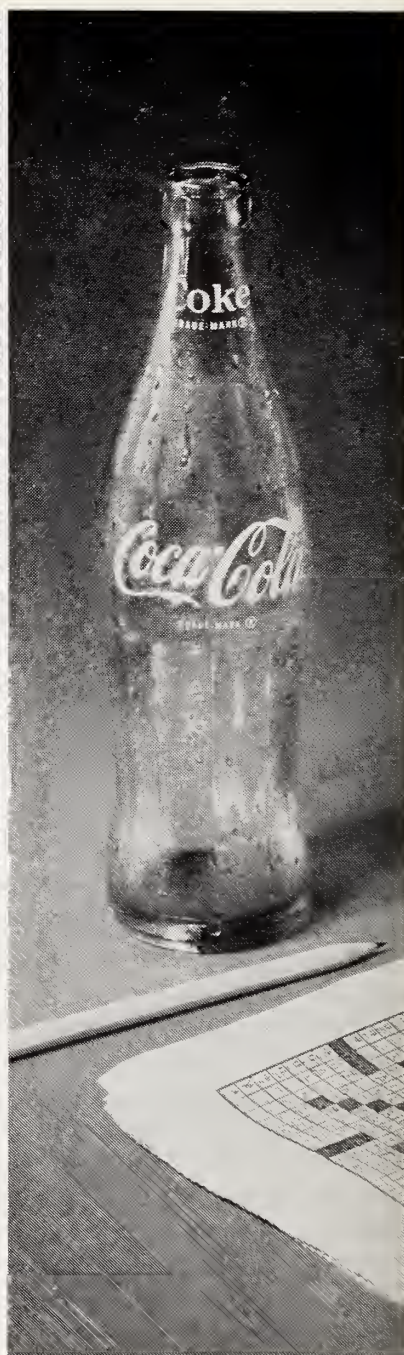




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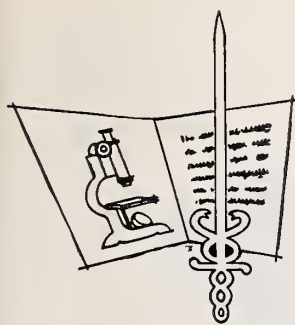
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### CONTROL OF BASAL CELL CARCINOMA

Harold S. Engler, M.D. and George F. McInnes, M.D., *Augusta*

**B**ASAL CELL CARCINOMA of the skin is a common lesion and usually can be controlled by conventional methods of local excision or radiation therapy. However, in order to avoid failure in an individual case, the lesion should not be approached as "nothing but a little skin cancer." This common attitude toward basal cell carcinoma is understandable because of its slow growing nature, failure to metastasize, tendency to stay localized and very high expected cure rate with relatively simple treatment.

#### Can Lead to Disaster

Those who deal with many cancer patients realize that this simple lesion can lead to disaster. This tumor can kill as surely by local invasion and persistence as can squamous cell carcinoma. Because of the more frequent occurrence in the head and neck region, an uncured basal cell carcinoma can result in deep invasion of vital structures. The radical surgery required for extirpation may leave the patient with loss of lip, eye, ear or nose—all really irreplaceable even though the cosmetic repair attempt may appear to be satisfactory.

Even with adequate wide excision the recurrence rate is high, and over the years repeated attempts to cure the lesion becomes the history of many. The loss of an eye, deep invasion of bone or extension to dura and brain all seem so tragic and unnecessary considering how easily curable the lesion might have been at some earlier stage.

There are several reasons for failure to excise completely. The most important is that often only a small portion of the tumor presents above the surface of the skin, while a larger, invasive component is located beneath the skin and may be growing laterally in several directions. The elliptical excision of the surface component often results in a pathology report which reads, "tumor extends to all surgical margins." In such a lesion it is necessary for the surgeon to realize that the extent of the underlying lesion cannot be decided upon by what is apparent on the surface and that the margins must be made widely.

#### Location of Lesions

Many lesions are located in areas not allowing easy primary closure. Those lesions over the dorsum of the nose, near the inner canthus of the eye, on the upper lip or ear often have to be excised so widely that primary closure cannot be accomplished without tension on the suture line. The principle in all such excisions should first be that of totally excising the lesion and then reconstructing with whatever technics are necessary.

It is most imperative on any lesion to excise with adequate lateral and deep margins so that this will be the only procedure necessary.

*Talmadge Memorial Hospital*

Approved by the Professional Education Committee, Georgia Division, ACS.

### CLINICAL CENTER STUDY OF HODGKIN'S DISEASE

The cooperation of physicians is requested in a continuing study of Hodgkin's disease being conducted by the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Particularly desired are patients who have had no previous treatment or minimal prior treatment. All clinical stages of biopsy-proven disease are acceptable. The major purpose of the study is to determine the curative

potential of intensive radiotherapy in localized cases and to evaluate combination chemotherapy and X-irradiation in patients with generalized involvement.

Physicians interested in having their patients considered for the study may phone or write to: Paul P. Carbone, M.D., The Clinical Center, National Institutes of Health, Building 10—Room 12-N-228, Bethesda, Maryland 20014. Telephone: 656-4000, Ext. 64251 (Area Code 301).



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**IN BRIEF:** One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy— withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

**Supplied:** CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

<sup>1</sup> Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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## CHRONIC COR PULMONALE

James K. Van Buren, M.D., *Atlanta*

**C**OR PULMONALE may be defined as right ventricular hypertrophy (RVH), resulting from diseases affecting the function and/or the structure of the lung, except when these alterations are the result of diseases that primarily affect the left side of the heart, or congenital heart disease. The chronic form, as distinguished from the subacute or acute forms such as carcinomatous infiltration of the pulmonary vasculature or acute pulmonary embolism, is by far the most important in terms of incidence. Chronic bronchitis and/or emphysema represent the major diseases causing chronic cor pulmonale.

### No Simple Criteria

While there is no simple definitive criteria for the diagnosis of RVH, a careful evaluation of the clinical, radiological, electrocardiographic, and hemodynamic findings will frequently lend much weight to its diagnosis. However, it must be appreciated that the underlying lung disease may conceal cardiac findings. Frequently, there is no observable cardiac abnormality on x-ray or abnormal EKG even though anatomic RVH is present. Thus, the diagnosis of chronic cor pulmonale depends largely on recognition of the evolution of the underlying pulmonary disease.

### Increasing Dyspnea

Patients with pulmonary emphysema have progressively increasing dyspnea as their major symptom. (This alone may be confused with heart failure but careful evaluation will not reveal the diagnostic signs of failure.) There may be no cough. Usually there is x-ray evidence of emphysema. Near normal oxygen saturation is maintained by hyperventilation. The arterial  $p\text{CO}_2$  may be normal or low. Simple pulmonary function studies may show a normal or slightly elevated vital capacity, but diminished expiratory flow rates indicating expiratory obstruction. This picture may remain relatively unchanged until an acute respiratory infection throws the patient

into acute respiratory insufficiency with the signs and symptoms of cardiac failure. Treatment of the underlying pulmonary condition as well as of the heart failure may return the patient to his former state.

Perhaps the more frequent history is that of chronic bronchitis with or without emphysema but dominated by hypoventilation. Initially productive cough may be the only clinical finding. Later more frequent and disabling respiratory infections with dyspnea are seen. At this stage abnormal expiratory function with obstruction is seen. Mild hypoxia and normal to slightly elevated arterial  $p\text{CO}_2$  are found. Cyanosis is frequently seen. Under the stress of acute infections more severe hypoxia and hypercapnia with the signs and symptoms of congestive heart failure become manifest. Clinical features particularly present in such alveolar hypoventilation states with congestive failure are central (hypoxemic) cyanosis, mental confusion, warm peripheral extremities, jerky twitching or tremors of the fingers, and polycythemia.

### Aimed Treatment

Treatment is necessarily aimed at both the heart failure and the underlying pulmonary disease. In general, the treatment of the heart failure in cor pulmonale does not differ essentially from other kinds of heart failure. Vigorous attention to the avoidance of all bronchial irritants such as cigarette smoking, prompt treatment of infections, improvement in ventilation through the proper use of bronchodilators, mechanical measures such as postural drainage, and assisted ventilation when necessary are of primary importance.

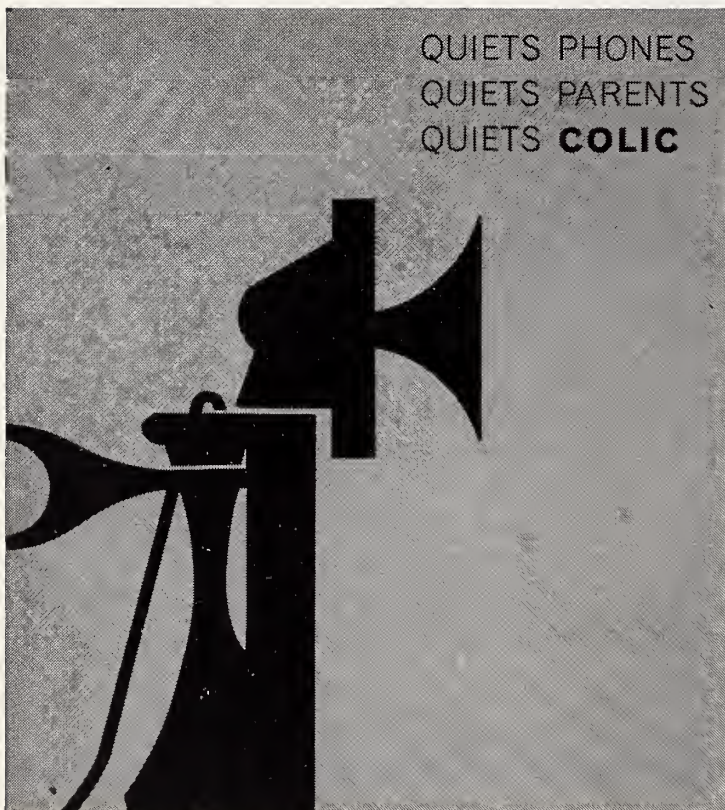
By such a vigorous and optimistic approach, frequently the end stages of these diseases can be delayed. Indeed, the preventive approach becomes more a reality.

*768 Juniper Street, N.E.*

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.



## **PEDIATRIC PIPTAL® WITH PHENOBARBITAL**

each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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# ERYTHROCIN<sup>®</sup>-SULFAS

## Brief Summary

**Indications:** Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

**Contraindications:** Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

**Warnings:** As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

**Precautions:** Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

**Adverse Reactions:** Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

**Supplied:** The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303



## HIGHLIGHTS OF THE ACTIONS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL PHONE CALL CONFERENCE MEETING NOVEMBER 18, 1966

*This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.*

**Usual and Customary Charges** by physicians seeking reimbursement for services rendered to eligible recipients of state agency programs (Family & Children Services, Vocational Rehabilitation, and Workmen's Compensation) was discussed relative to the Association's notification to these state agencies of MAG policy on this matter. Replies to the Association notification to these state agencies were read and the Executive Committee approved letters of further clarification from MAG in response to these replies—emphasizing the 1966 MAG House of Delegates policy.

**Automobile Safety Petitions** to the Georgia General Assembly for their consideration in legislative action during the 1967 session was presented for MAG approval on recommendation of the MAG Auto Traffic Safety Committee. These petitions, sponsored by the Georgia Association of Independent Insurance Agents, were endorsed by MAG Executive Committee for mailing to County Medical Societies for physicians' signatures.

**Military Medicare Program Expansion** informational mailings to doctors of medicine, pharmacies, and hospitals were reported in progress by MAG as the Fiscal Administrator for this program. MAG Executive Committee authorized the employment of an additional R.N. for the Headquarters Office staff to assist in processing the increased volume of claims necessitated by the expanded benefits under the program.

**Proposed Resolution to AMA** on liaison between AMA and pharmaceutical manufacturers, as presented to MAG Council at their September 1966 meeting, was deferred for further consideration by Council with the concurrence of the author of the resolution. Because of additional information on this subject, Executive Committee recommended that the matter be discussed at the December 1966 Council meeting for disposition at that time.



For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.

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FOR COLD  
HANDS AND FEET**



## GERILID<sup>TM</sup>

Each chewable tablet contains:  
nicotinic acid (niacin) 75 mg. and  
aminoacetic acid (glycine) 750 mg.

**Administration and Dosage:** One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

**Side effects:** Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

**Supplied:** Packages of 50 chewable tablets.

Also available in liquid form as Geriliquid®, in bottles of 8 and 16 ounces.

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## VOLUNTARY HOSPITALIZATION OF THE MENTALLY ILL

Sheldon Cohen, M.D., *Atlanta*

**W**HAT DOES A PHYSICIAN do when confronted with a patient who realizes that he is mentally sick and is willing to go to a hospital if so advised by his doctor? If the patient is in a position to afford private care, the answer is quite simple. He is referred to the appropriate private facility where admission and treatment are accomplished with as little fanfare as would be the case if he were admitted to a general hospital for treatment of appendicitis or a broken leg. What is not generally realized is that the procedures for admitting a mentally ill person to a state institution on a voluntary basis are just as simple.

### A Brief Note

If a physician decides that a patient should be hospitalized in a state institution and the patient willingly accedes to this recommendation, he should write a brief note to this effect, preferably on his office stationery. (If circumstances allow, it is suggested that this note be typewritten by the secretary, giving the doctor a copy for his own records.) The note should be simple, clearly stating the patient's major symptoms and diagnosis. For example, "Mr. John Smith, age 47, who has been a patient of mine for the past 12 years, is currently suffering from feelings of depression, anxiety, insomnia, and has had suicidal ruminations. My impression is depressive reaction and I strongly recommend admission to the state hospital for such treatment."

Under usual circumstances the patient and family then take this note to the county health department,

which then makes necessary arrangements regarding bed space. Although this is the preferred route administratively, if the need for hospitalization is imperative (weekends, holidays, etc.), the patient and family may be sent directly to the state hospital at Milledgeville.

### Some Categories Not Admitted Voluntarily

Final determination regarding the desirability of admission, of course, is the responsibility of the admitting physician at the hospital. However, as a practical point, any patient who does suffer from serious mental symptoms will undoubtedly be admitted. However, the following three groups of patients are not admitted on a voluntary basis because experience has indicated that they will not stay and follow through with treatment procedures: (1) alcoholics and drug addicts, (2) persons previously admitted voluntarily who left against medical advice, (3) children under 18 years of age.

It should be stressed that voluntary admission of the mentally ill to the state hospital is *strictly a medical matter*. The delays, discomfort, embarrassment, and possible legal entanglements attendant upon commitment proceedings which go through the courts are avoided. Experience in other states has shown voluntary admission to be much more practical and efficient, with the vast majority of patients going to their state institutions on a voluntary basis.

*401 Peachtree Street, N.E.*

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*Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.*

## HOW TO GO TO SLEEP

Let us all remember that we must not prescribe just the dosage that is given in a book; we must give enough to produce the effect we desire. Also we must not rigidly prescribe a dose every four hours; it is better to tell the nurse to give enough of the medicine to relieve pain, and when the pain returns to give another dose. I learned much pharmacology years ago

when I watched a man quickly drink four martinis. He explained that he did not feel anything until he had four. And then I thought of the many times I had wondered why a man like that had to take three or four capsules of a barbiturate before he felt sleepy.—Walter C. Alvarez, M.D., in *Modern Medicine* (34: 106), March 14, 1966.



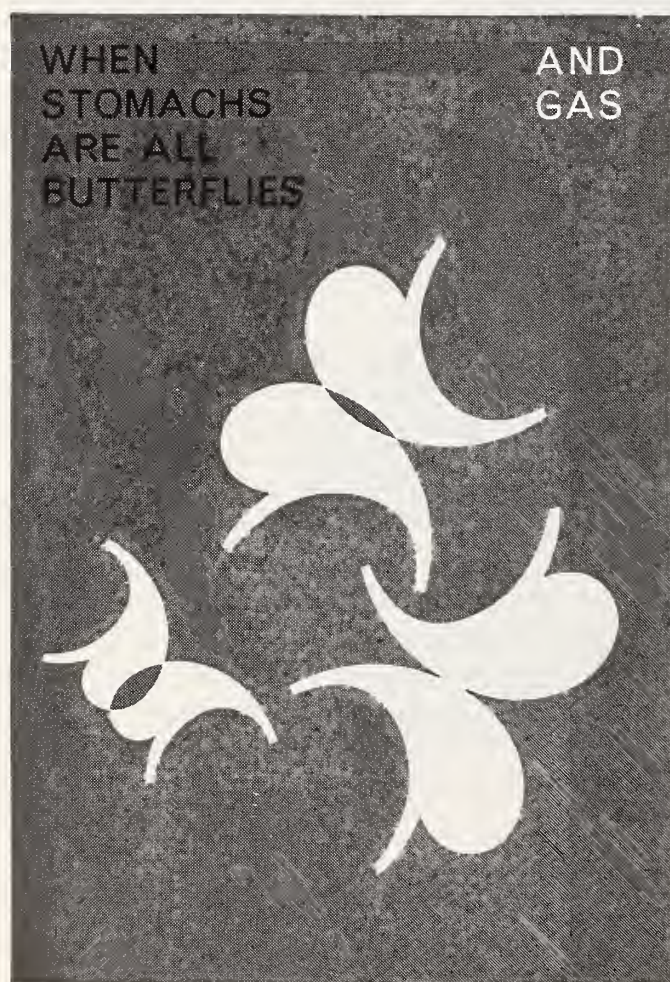
## DACTILASE®

Each tablet contains:

Dactil® (piperidolate hydrochloride), 50 mg.;  
Standardized cellulolytic\* enzyme, 2 mg.;  
Standardized amylolytic enzyme, 15 mg.;  
Standardized proteolytic enzyme, 10 mg.;  
Pancreatin 3X\*\* (source of lipolytic activity),  
100 mg.; Taurocholic acid, 15 mg.

\*Need in human nutrition not established.

\*\*As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

### Side Effects and Contraindications:

Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

**Administration and Dosage:** One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

**Supplied:** Bottles of 60 and 250.

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### RENEW YOUR MEDICAL LICENSE

John Kirk Train, III, *Atlanta*

**R**ECENTLY A QUESTION has been raised as to whether physicians are entitled to payment for fees charged for services rendered during a period of time when they have not renewed their licenses to practice medicine with the Secretary of State of Georgia. We had to express the opinion of our firm that physicians would not be entitled to charge for such services until such time as they had renewed their licenses.

#### Provisions of Law

The Ga. Code § 84-915 states that the license to practice medicine issued by the State Board of Medical Examiners gives absolute authority to the person to whom it is issued to practice medicine in this State. However, in 1956, the Georgia General Assembly added a second paragraph to § 84-915 which reads in pertinent part as follows:

"All licenses to practice medicine shall expire on December 31 of each year and shall become invalid on that date unless renewed. The fee for renewal shall be \$3.00. On December 1, the Joint Secretary, State Examining Boards, shall mail to each person holding a license to practice medicine a blank to be used [for renewal]. Upon receipt of the application and renewal fee, the Joint Secretary . . . shall be authorized to renew a license. Failure to apply for renewal and to remit the license fee during the month of December shall not withdraw the right of renewal, but the renewal fee if submitted after December 31 shall be \$10.00."

Section 84-906, dealing with the unauthorized practice of medicine, does not just require that a physician be duly issued a license. It specifically states that if one holding himself out to be a physician does not "then possess in full force and vir-

tue a valid license to practice medicine under the laws of this State," he is deemed to be practicing medicine without complying with the provisions of the Licensing Act and in violation of it. Similarly, the criminal section of the Licensing Act, § 84-9914, says:

"Any person guilty of practicing medicine without complying with the provisions of Chapter 84-9, or any person who shall violate the provisions of said Chapter shall be deemed guilty of a misdemeanor."

In view of the fact that § 84-915 states in so many words that licenses to practice medicine *expire* at the end of each calendar year and *become invalid* at that time unless renewed, it would seem that a physician who fails to renew his license does not, while the license is unrenewed, "possess in full force and virtue a valid license to practice medicine."

#### Renew Your License

There seems to be little point in running any risk on this subject and it is strongly recommended that members of the Association complete the form sent by the Joint Secretary of the State Examining Boards and send it promptly to the Joint Secretary with the \$3.00 fee. If that step is taken annually no question can be raised as to the physician's ability to collect either privately or under public programs for services rendered to patients and no question can arise that the physician is possibly guilty of a misdemeanor for practicing without a license.

Suite 1220  
C & S Bank Building

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*Prepared at the request of The Medical Association of Georgia. Mr. Train is an associate in the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.*

### HOW TO BEAT THE ANTIVIVISECTIONISTS

When it comes to combating the tearful testimony of the various antivivisectionist groups we may be required to become just as emotional by using the testimony of grateful people who now live because of the contribution animals have made to medical knowledge.

We must not be complacent. This is the year for the antivivisectionist—unless we combat emotions with truth.—Daniel B. Powell, M.D., in *Texas Medicine* (62:27-28), February, 1966.



WHAT'S THE  
COMMON  
DENOMINATOR? ...IRON



In fact, there's as much iron...250 mg.  
...in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood.  
When iron deficient patients are intolerant of oral iron...or orally administered iron proves ineffective or impractical...or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves.

## IMFERON® (iron dextran injection)

**IN BRIEF: ACTION AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a *source of iron*; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

**COMPOSITION:** Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

**ADMINISTRATION AND DOSAGE:** Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

**SIDE EFFECTS:** Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

**PRECAUTIONS:** If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

**CONTRAINDICATIONS:** Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

**CARCINOGENICITY POTENTIAL:** Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

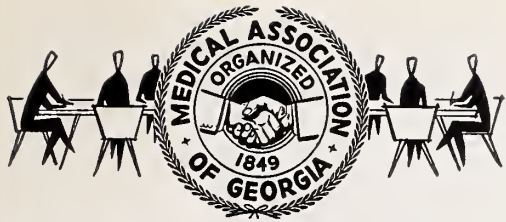
**SUPPLIED:** 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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# THE ASSOCIATION

## DEATHS

**William H. Bateman**, former Mayor of Forest Park, died September 27, 1966, of a heart attack in Georgia Baptist Hospital, Atlanta. Dr. Bateman was 50 years old. Dr. Bateman is survived by his wife, Agnes, and five children, and two brothers, Needham Bateman and Gregory Bateman.

**Wade R. Bedingfield** of Augusta died October 10, 1966. Dr. Bedingfield served his internship at the University Hospital, Augusta, and residencies at St. John's Hospital, New York; St. Vincent's Hospital, Staten Island, New York; and the New York Eye and Ear Infirmary, New York City. He was a member of the Richmond County Medical Society, the Medical Association of Georgia, and the American Medical Association.

**R. Frank Cary**, Macon, died October 11, 1966, after an illness of several weeks.

He was educated at Emory University and Johns Hopkins University and practiced medicine in Monticello for 25 years. For 15 years he was director of the Bibb County and Jones County Health Departments. Following his retirement he served on the staff of the Milledgeville State Hospital.

He was a member of the Bibb County, Georgia and American Medical Associations, the Georgia and American Health Associations, and the Public Health Officers Association. He was a member of the Vineville Methodist Church and a former member of the Macon Rotary Club.

Survivors include his widow, the former Mrs. Pearl Harrison Bonner of Macon; one sister, Mrs. C. F. Bloodworth of Slocumb, Alabama; and one stepson, Robert Bonner of Tarboro, North Carolina.

**Ernest Felber**, Atlanta urologist, died October 29, 1966, in a private hospital.

A urologist in Atlanta since 1938, Dr. Felber was on the staff of St. Joseph's Infirmary and the Hughes Spalding Pavilion and was official doctor for the British Consulate General and the German Consulate.

A native of Austria, Dr. Felber studied medicine in Prague and Vienna. After graduation from the Vienna School of Medicine he served as a medical staff captain in the Austrian-Hungarian army during World War I.

He interned under, and was later assistant to, the Viennese urologist Dr. Otto Suckerandl and later headed the Urology Department of the Maria Hilfer Ambulatorium in Vienna.

Survivors include his wife, and a daughter, Mrs. Paul Gravohl, Paris, France.

**Paul Louis Schroeder**, an Atlanta psychiatrist who was one of ten international psychiatric consultants at the Nuremberg war trials and was later clinical professor of child psychology at Emory University and director of the Atlanta Child Guidance Clinic, died October 27, 1966, in an Atlanta hospital.

Dr. Schroeder, as a consultant in neuropsychiatry for the Fourth Service Command during World War II, was selected as one of 10 specialists from five countries to serve as a consultant at the International Military Tribunal in Nuremberg, Germany, in 1945 and 1946.

Dr. Schroeder retired as a colonel.

A native of Hoyleston, Illinois, Dr. Schroeder returned after the war to Atlanta, where he had served for a short time while in the Army.

Since 1949 he had been a clinical professor of child psychology at Emory University School of Medicine and was director of the Child Guidance Clinic, in addition to conducting a limited private practice.

Dr. Schroeder also had served on the Community Planning Council and the Citizens Crime Prevention Council. He had also practiced as the consulting psychiatrist for the Child Welfare Association.

Dr. Schroeder also organized the pilot program at Grady Hospital which demonstrated the value of treatment locally to avoid transfer of patients to Milledgeville State Hospital.

A 1919 graduate of the University of Illinois Medical School, Dr. Schroeder was director of the Illinois Institute for Juvenile Research from 1929 to 1947, criminologist for the Illinois Department of Public Welfare from 1930 to 1942, professor of psychology at the University of Illinois Medical School, consultant to the Illinois Pardon and Parole Board and organizer of the psychiatric unit at St. Joseph's Hospital in Chicago.

He was the author or co-author of numerous articles and books, including "Child Guidance Procedures," and "Medico-legal Problems," and served as a member of the editorial board of the *Journal of Criminal Psychopathology*.

Dr. Schroeder was a life member of the American Psychiatric Association, a member of the American Association of Child Psychiatrists, the National Committee for Mental Hygiene, the American Orthopsychiatric Association of which he was president in 1940, the Fulton County, Georgia and American Medical Associations, and was a charter member of the Georgia Psychiatric Association.

He also was a member of the American Prison Congress of which he served as president of the medical section in 1938-40, a life fellow of the Southern Psychiatric Association, and a member of Alpha Omega Alpha and Sigma Psi honorary fraternities.

Survivors include his wife, the former Julia Nolen; two daughters, Mrs. Richard Dell, Middletown, Ohio, and Mrs. James Wall, LaGrange, Illinois; a son, Robert Schroeder, New Orleans, Louisiana; two sisters, Mrs. Otto Brandhurst, St. Louis, Missouri, and Mrs. Reynolds Stahl, Bonne Terre, Missouri, and two brothers, Dr. Fred Schroeder and Dr. Carl Schroeder, both of Nashville, Illinois.

**Cosby Swanson**, formerly of Atlanta, died October 1, 1966, in St. Petersburg, Florida.

He was a professor of dermatology at Emory Uni-



## THE ASSOCIATION / Continued

versity for 25 years and headed the cancer clinic at Georgia Baptist Hospital for a number of years.

He served as an instructor of nurses on the staffs of Emory, Georgia Baptist, Grady Memorial, St. Joseph and Crawford Long hospitals.

He was the last charter member of the group that organized the Dermatological Association.

Born in Fairburn, he was a former member of the Second Ponce de Leon Baptist Church.

He was a graduate of the University of Louisville School of Medicine and did graduate work at the New York Skin Cancer Hospital, St. Mary's Memorial Hospital in London and St. Louis Hospital in Paris.

He had resided in St. Petersburg for several years.

Surviving are his widow, the former Vee Strickland; a daughter, Mrs. William R. Shupert, Atlanta; a son, Cosby Swanson, Jr., St. Petersburg; sisters, Mrs. J. C. Langston, Fairburn, and Mrs. Nora Gedding, Washington, D. C., and six grandchildren.

## COUNTY MEDICAL SOCIETIES

Honored recently at a meeting of the **Georgia Medical Society**, Savannah, were 13 senior members of the society who began practice between 1900 and 1924. They have a combined total of 540 years in the medical profession. Those honored were E. S. Osborne, J. C. O'Neill, Rufus E. Graham, E. N. Gleaton, W. V. Long, G. H. Faggart, J. K. Quattlebaum, Robert Drane, G. C. Redmond, M. H. Egan, J. S. Howkins, G. H. Lang, and H. Y. Righton.

The **Ninth District Medical Society** met in Winder September 21, 1966, with the **Barrow County Medical Society** serving as host. A scientific program was presented in the early afternoon by members of the faculty of the Emory University School of Medicine. The program was as follows:

"Modern Contraception Loop versus Pill," by Dr. Armand E. Hendree, Assistant Professor of Obstetrics and Gynecology, and Chief of Staff of Obstetrics and Gynecology, Emory Hospital.

"Choice of Antibiotics in Common Infections," by Dr. William M. Marine, Associate Professor of Preventative Medicine.

"Bedside Diagnosis of Cardiac Arrhythmias," by Dr. Edward Dorney, Associate Professor of Medicine.

"Current Trends in Surgery of Occlusive Peripheral Vascular Disease," by Dr. Robert Smith, III, Instructor in Surgery, Grady Memorial Hospital and Veterans Administration Hospital.

A business meeting followed the program.

**Ocmulgee County Medical Society** held its quarterly meeting in September in Eastman, at which time new officers for 1967 were elected.

The new officers are: president, Dr. Hart Sylvester, Hawkinsville; secretary and treasurer, Dr. Mac Johnson, Eastman; delegate to the Medical Association of Georgia, Dr. Richard S. Smith, Cochran.

Past president, Dr. Hal Conner, of Eastman, appointed a committee on Mental Health to serve the Ocmulgee Medical Society area in developing and establishing a concrete and constructive Mental Health program with local aid and civic organizations. This committee was comprised of chairman, Dr. Mac Johnson, Eastman;

Dr. Blake S. Bivins, Cochran; Dr. William E. Coleman, Hawkinsville, and Dr. William T. Durham, Abbeville.

The **Second District Medical Society** held their semi-annual meeting in Blakely October 6, 1966. Scientific presentations were given by Walter Bloom, M.D., Atlanta, "The Newer Treatment for Obesity"; James W. Oglesby, M.D., Albany, "Chest Diseases"; and J. C. Tanner, Jr., M.D., Atlanta, "The Tanner-Vandemput Mesh Dermatone."

## PERSONALS

**Carl C. Aven**, of Marietta, representing the Medical Association of Georgia, was appointed to the "Advisory Committee on Programs for Retired Professionals" which met June 13, 1966, at Athens, Georgia. Serving on this Committee are outstanding persons who have retired from the fields of Medicine, Education, Law, Chemistry, Physics, Journalism, Health Education and Civic Affairs.

The purpose of this newly formed Committee is to seek out ways and means of utilizing the skills and talents of retired professionals so that these persons may continue to make productive contributions to their communities and society. Dr. Aven was appointed by this Advisory Group to a four-man steering committee to define the scope and objectives of the group. A further report will be made at a later date on this project.

The American College of Surgeons has inducted 28 Georgians as new Fellows. The fellowships were awarded at the group's annual clinical congress held in San Francisco recently. New members from Georgia are:

**Dr. Harvey L. Simpson, Jr.**, of Americus; **Drs. J. Hagan Baskin, Jr., Fred M. Bell, Jr., John T. Blasingham, Jr., Carl R. Hartrampf, Jr., James W. Morgan, William J. Pendergrast, Richard A. Smith, H. Harlan Stone, Panagiotis N. Symbas and L. G. Walker, Jr.**, all of Atlanta; **Drs. Marshall B. Allen, Jr., Henry T. Edmondson, Jr., Ronald F. Galloway and Robert A. Parrish, Jr.**, of Augusta.

**Dr. Peter C. Sotus** of Chamblee, **Dr. Edmund M. Molnar** of Columbus, **Dr. Catherine E. Foster** of Decatur, **Dr. Fernando U. Duralde** of East Point, **Dr. J. Lamar King** of Griffin, **Dr. James D. Lawrence** of Macon, **Dr. William M. Headley** of Milledgeville, **Dr. Archie J. Morris** of Monteuma, **Dr. Charles B. Thomas** of Newnan, **Dr. Boyce S. Brice** of Rome, **Drs. Clarence W. Rawson, Jr., and Cheng-Tsuau Su** of Savannah, and **Dr. James F. Kirkpatrick, Jr.**, of Tifton.

**Zellner Young**, Ft. Valley, has been named Chief of the medical staff of the Chatham Nursing Home, Savannah. He is a staff physician with the Savannah Heart Clinic and is Secretary of the Memorial Hospital medical and dental staff.

The Hospital Authority of Chatham County has elected **Joseph Pacifici** of Savannah to replace **James Metts** as one of the members of the board.

**P. L. Hilsman** of Albany has resigned his post as county physician to accept a position with the State Vocational and Rehabilitation Service in Atlanta. Dr. Hilsman assumed his duties October 1, 1966.

**Jay Goldstein**, Warner Robins physician, was presented a USO 25th Anniversary Award in recognition



of his long standing service on the USO Council. Dr. Goldstein is a charter member of the USO Council and has served on it since its inception at Warner Robins in 1945.

**Ben H. Jenkins** of Newnan is one of three physicians in the U. S. to have been certified for travel in Red China for the purpose of research. It was announced recently in *Science*, a publication of the American Association for the Advancement of Science.

**Gerald T. Zwiren**, Atlanta, addressed a nursing conference of the American College of Obstetricians and Gynecologists meeting held recently in Atlanta. His topic concerned three tests which nurses may give newborn babies to determine their physical and mental normality.

**Alfred A. Messer** presented a paper at the American Psychiatric Association Meeting in Hollywood, Florida, October 23-26, 1966, entitled, "Treatment of Marital Conflict—A Public Health Approach."

**J. Frank Walker** of Atlanta was elected Vice Chairman of the Board of Chancellors of the American College of Radiology at their recent meeting held in San Francisco. Dr. Walker's term will begin following the February meeting of the College.

**Waddell Barnes** of Macon has been named Chairman of an 11 member advisory committee to work with the building committee of Macon Hospital in planning the expansion of the hospital.

**L. A. Erbele**, Macon, is now associated with Middle Georgia Hospital as pathologist and will supervise the hospital's laboratories and laboratory personnel.

**Howard M. Sigal** of Smyrna was among 63 physicians from the U. S. and Mexico who convened in Boston, September 19-23, 1966, for an intensive post-doctoral course in pediatrics. The course was offered at The Children's Hospital under the auspices of Courses for Graduates, Harvard Medical School.

## NEW SERIES ON EDUCATIONAL TV TO BE PRESENTED BY GEORGIA HEART ASSOCIATION

A new series of educational programs on Heart Disease will be presented for Georgia physicians on Georgia's Educational Television Network. The series began this November.

### To Begin Second Year

Under auspices of the Georgia Heart Association, 12 monthly, professional-level programs will be telecast by the ETV network on such cardiovascular subjects as "Reversible Heart Disease," "An Approach to Peripheral Vascular Disease," "Congenital Heart Disease in Infants," etc. This series is beginning its second year on the Georgia Educational Television Network and has received statewide acceptance.

The programs will appear on the first Monday and Tuesday of each month, after completion of regular programming. On the evenings of the GHA-sponsored programs, the ETV network will be reactivated at 10:30 for the special hour-long telecast.

At a recent meeting of the Medical Staff of Hamilton Memorial Hospital, Dalton staff officers, chiefs of services and clinic directors were elected. They are **Earl T. McGhee**, chief of medicine; **R. T. Farrow**, secretary; **S. L. Sellers**, president; **R. L. Raitz**, vice president; **Sherwood Jones**, director of the Heart Clinic; **Murray B. Lumpkin**, director of the Judd Memorial Tumor Clinic; **David Nowell**, chief of obstetrics and gynecology, and **Paul L. Bradley**, chief of surgery.

**Claude V. Vansant, Sr.** of Douglasville was recently honored at a surprise birthday party at the Georgian Villa Nursing Home. Dr. Vansant is 80 years old.

**Tom Harbin** of Rome was recently elected Secretary of the House of Delegates of the American Association of Ophthalmology at the recent meeting in Chicago.

**Vilda Shuman** of Waycross, Immediate Past President of Pilot Clubs International, was a guest speaker on the radio program, American Credo, October 2, 1966. The program is sponsored by the Freedoms Foundation, Valley Forge, Pennsylvania.

**D. Hartwell Boyd**, St. Simons Island, has been appointed to the Hospital Authority of the Brunswick City Commission replacing the previous member who had resigned.

**William H. Rhodes, Jr.**, of Union Point, has been accepted for membership in the Georgia Chapter of the American Academy of General Practice.

The first of two teams of Medical College of Georgia physicians will leave for a two-month tour in a Viet Nam civilian hospital in January. **Edwin L. Brackney**, Professor of Surgery, will spend two months working at Da Nang Civil Hospital. **George McInnes**, Assistant Clinical Professor of Surgery, returned from the hospital in September where he headed the surgical team. The second team, **Charles Wray**, Assistant Professor of Surgery, will leave in May.

**J. Hubert Milford**, Hartwell, attended the Annual Scientific Assembly of the American Academy of General Practice in Boston in October.

The faculties for this new series of programs will consist of outstanding physicians throughout the nation. Many Georgia physicians are already within range of one of the five ETV transmitters and all will be when the state completes the entire network. The most recent addition to the network is WCES, Channel 20, in Wrens, Georgia.

### Program Dates and Subjects

The program dates and subjects are: *January 2-3*, "The Nature of Hypertension"; *February 6-7*, "Use of Anticoagulants in Clinical Disease States"; *March 6-7*, "Reversible Heart Disease"; *April 3-4*, "An Approach to Peripheral Vascular Disease"; *May 1-2*, "Congenital Heart Disease in Infants"; *June 5-6*, "Renal Vascular Hypertension"; *July 3-4*, "Cardiac Pacemakers—Part I"; *August 7-8*, "Cardiac Pacemakers—Part II"; *September 4-5*, "Value of Cardiac Catheterization"; and *October 2-3*, "Heart Surgery in Adults."



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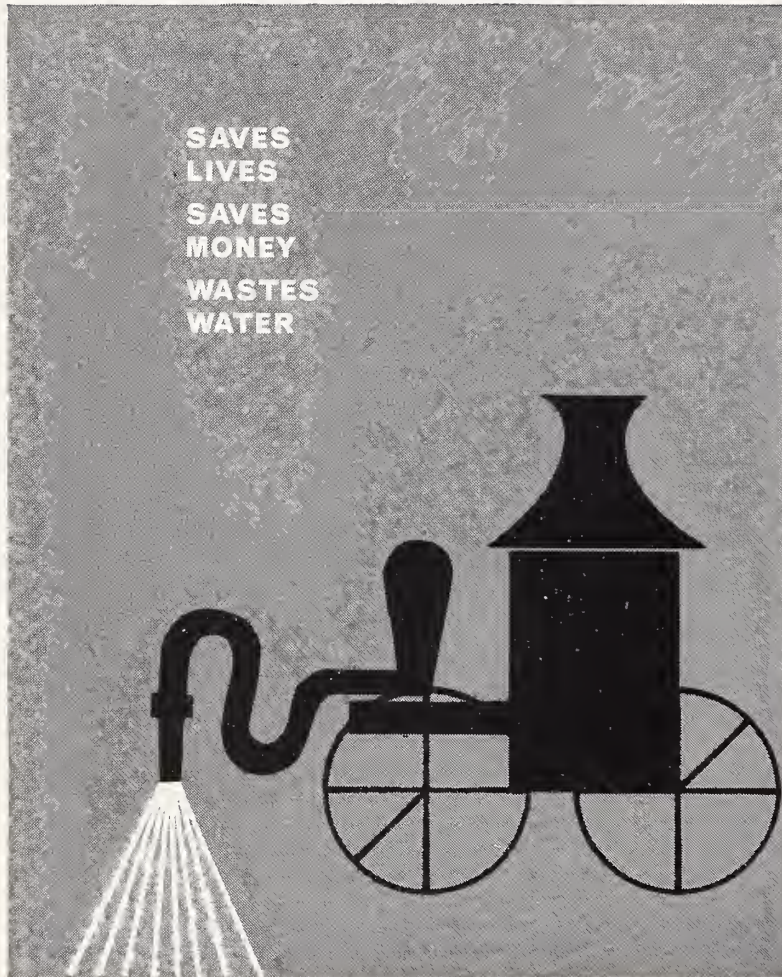
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